MedCare Partners
Health Plan of Texas

GRIEVANCE or APPEAL REQUEST FORM

You may use this form to submit a request for an appeal or grievance related to medical items, services, or Part B drugs. To appeal a denial of a Part D drug, please use the Redetermination Form found at https://mcpartnerstx.com/prescription-drug-coverage/. For grievances related to Part D drugs, call MedImpact at 1-833-229-0180 (TTY 711).

Name of Person Submitting Request: _____

☐ **Member**

☐ **Authorized Representative (see the Appointment of Authorized Representative section below)**

CONTACT INFORMATION OF AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

Address	City	State	Zip Code
Phone Number			

MEMBER INFORMATION

First Name	Last Name	Member ID Number	
Address	City	State	Zip Code
Phone Number	Date of Birth		

TREATING PHYSICIAN/HEALTHCARE PROVIDER INFORMATION (IF APPLICABLE)

Name	Phone Number		
Address	City	State	Zip Code
Email Address	Fax Number		
Contact Person	Phone Number		

GRIEVANCE/APPEAL DETAILS

DATE OF SERVICE (IF APPEALING A DENIED CLAIM)
TYPE OF SERVICE (IF APPEALING A DENIED PRE-SERVICE AUTHORIZATION)
DATE OF INCIDENT (IF FILING A GRIEVANCE)

DESCRIPTION AND REASON FOR GRIEVANCE OR APPEAL (ATTACH ADDITIONAL DOCUMENTATION, IF APPLICABLE).

APPOINTMENT OF REPRESENTATIVE

If you are filing a grievance or appeal on the member's behalf, you must submit documentation to support your legal status as the member's representative. Examples of legal representatives include a Power of Attorney (POA), legal guardian, healthcare proxy, person designated under a health care consent statute, or an executor of an estate. If you do meet these requirements, you and the member must complete an Appointment of Representative (AOR) form. You can find a copy of the AOR form on the web at https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms1696.pdf or you can call our Member Services Department and request that a copy of the form be mailed to you. We cannot act on a request from a representative without the appropriate legal documentation or AOR form.

SUBMISSION

Send this form and a copy of your representative documentation or AOR form (if applicable):

MedCare Partners Health Plan of Texas
11602 Bellaire Blvd., Suite C
Houston, TX 77072

You may also fax your request to 1-888-200-3558.

For more information, please contact Member Services at 1-866-627-8901 (TTY users can call 711), 7 days a week from 8 am to 8 pm (except Thanksgiving and Christmas Day) from October 1 – March 31 or Monday through Friday from 8 am to 8 pm (except for Federal holidays) April 1 – September 30.