

Member Grievance Form

BEFORE YOU START:

Absolute Total Care will review and resolve your grievance as quickly as possible and within **90 calendar days**. If additional time is needed, or if more information is required and the delay is in your best interest, we may extend the review by up to **14 calendar days**. If an extension is applied, you or your authorized representative will be notified by phone and in writing.

You may authorize a provider or another person to act on your behalf by completing an **Appointment of Authorized Representative Form**, available on our website at absolutetotalcare.com.

For additional details, please refer to your Member Handbook. If you need help filing a grievance, please contact Member Services.

HOW TO SUBMIT:

Mail: Absolute Total Care
Attn: Grievance and Appeals
100 Center Point Circle, Ste. 100
Columbia, SC 29210

Fax: 1-866-918-4457
Email: ATC-Appeals_Grievances@centene.com
Phone: 1-866-433-6041 (TTY: 711)

Section 1: Member Information

Member Name: _____

Member ID: _____ **Date of Birth (MM/DD/YYYY):** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Email Address:** _____

Preferred Contact Method

- ☐ Phone
☐ Email
☐ Mail
☐ Other: _____

Language or Communication Assistance Needed

- ☐ No
☐ Yes, please describe: _____



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Section 2: Person Filing This Grievance

Who is filing this grievance?

- ☐ Member
- ☐ Spouse
- ☐ Parent/Legal Guardian
- ☐ Authorized Representative
- ☐ Provider on behalf of the Member
- ☐ Other: _____

Name of Person Filing: _____

Relationship to Member: _____

Phone Number: _____ **Email Address:** _____

Section 3: Grievance Category

What is this grievance about? Check all that apply.

- | | |
|--|---|
| ☐ Access to care or services | ☐ Provider office site quality |
| ☐ Provider experience | ☐ Quality of care |
| ☐ Customer service | ☐ Transportation |
| ☐ Billing or payment concern | ☐ Pharmacy |
| ☐ Reimbursement for paid service(s) | ☐ Medical issue |
| ☐ Other: _____ | |

Section 4: Billing Information

Complete this section only if your grievance is about a bill or payment concern.

Provider Name: _____ **Provider Phone Number:** _____

Account Number: _____ **Amount Billed:** _____ **Date of Service:** _____

Did you include a copy of the bill?

- ☐ Yes
- ☐ No
- ☐ Not applicable

Continue



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Section 5: Tell Us What Happened

Please describe your grievance. Include dates, names, locations, and any other details that may help us review your concern.

Section 6: Supporting Documents

Are you including any supporting documents?

☐ No

☐ Yes

If yes, please list what you are sending:

Examples may include bills, letters, emails, appointment information, or other records related to your grievance.

Section 7: Signature

By signing below, I confirm that the information provided is accurate to the best of my knowledge.

Name: _____

Date: _____