Complaint and appeal form

Name of person filing complaint		Telephone no.	
Address	City	State	ZIP
Member name	Patient name	Member ID no.	
Name of provider involved	Address	Telephone no.	
Name of provider involved	Address	Telephone no.	
Date(s) of service			

Please write your complaint or appeal in the space below and on the back of this page. Attach additional pages if needed. You may include any document such as explanation of benefits (EOBs), correspondence, or invoices which will help us investigate your complaint or appeal. **Please sign and date this form.**

I certify that the above information is accurate and complete to the best of my knowledge. I have attached the most recent EOB from my previous carrier for each member listed on this form.

Signature X	Date

Ready to submit? Mail this form to Moda Health, Attn: Appeal unit, P.O. Box 40384, Portland, OR 97240 or fax to 503-412-4003 or 866-923-0412.

Questions? Contact a customer service representative at 855-294-1668.

modahealth.com

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