APPEAL FORM

We wish to provide you with the best obstetrical care possible through the Medicaid Maternity Care Program and to help you resolve any problems you may experience. You have the right to file a complaint/grievance with your Care Coordinator at any time. If you are not satisfied with the action taken by the Care Coordinator, your grievance will be escalated to an appeal and will be forwarded to the Grievance Committee. The Committee will then review your appeal and let you know what action has been taken to resolve it.

Please complete the following information:

Part I: To be completed by the Recipient.

Name: (First, Last , MI)	**Social Security #:**		
Street Address:	**City:**	**State:**	**Zip:**
Phone #:	**DCHP:**		
Please describe in detail why your complaint/grievance determination should be over turned:			

_____ _____ _____ _____

Recipient Signature **Date** **Care Coordinator** **Date**

Part II: Review by Grievance Committee

Action Taken:

_____ _____

Recipient Signature **Date**

☐ **Action Taken by telephone signature not available**

_____ _____

Care Coordinator Signature **Date**

Date Sent to Steps Ahead: _____

PLEASE SEND THIS COMPLETED FORM TO: Medicaid Maternity Care Program
PO Box 55947 BIRMINGHAM, AL 35255-5947 OR FAX TO 205-933-1235