Steps Ahead

APPEAL/GRIEVANCE PROCESSING 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 grievance with your Care Coordinator at any time. The Care Coordinator will attempt to resolve your grievance. 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 the complaint, problem, or grievance and how you would like it resolved:

_____

_____

_____

_____

_____

_____

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

Part II: To be completed by the Care Coordinator.

Action Taken:

_____

_____

_____

_____

_____

_____

Has the action resolved your complaint? ☐ Yes ☐ No

_____	_____
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