



Health Plan of Nevada Complaint Form

Member/Insured Name: _____

Member Number: _____ Date of Birth: _____

Description of the issue/concern (please include date(s), any known names of individuals involved; name of facility, if applicable):

Signature

Date

(If signed, a written response will be submitted to the member/insured)

WHEN COMPLETED, THIS FORM SHOULD BE SUBMITTED TO:

COMPANY NAME: Health Plan of Nevada
DEPARTMENT: Customer Response and Resolution Department
MAILING ADDRESS: P.O. Box 14865
Las Vegas, NV 89114-4865

As always, the Member Services Department can be contacted directly by telephone at the following numbers:

HEALTH PLAN OF NEVADA: (800) 777-1840
MEDICAID AND NEVADA CHECK UP (800) 962-8074
TTY 711