Health Plan of Nevada
A UnitedHealthcare Company

MEDICAID AND NEVADA CHECK UP

MEMBER GRIEVANCE 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):

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_____ _____

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: PO Box 14865
Las Vegas, NV 89114-4865

As always, the Member Services Department can be contacted directly at 1-800-962-8074.