Managed Care
OMBUDSMAN PROGRAM
A Division of the Office of the State Long-Term Care Ombudsman

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Medicaid Managed Care Complaint Form

Managed Care Ombudsman Program
Office of the State Long-Term Care Ombudsman

Date:_____

Individual Submitting Complaint: _____

Relationship to Medicaid Managed Care Member: _____

Address:

Phone: _____ Alternate Phone: _____

Email:_____

Medicaid Managed Care Member: _____

Medicaid ID: _____

Managed Care Organization:
- ☐ Amerigroup
- ☐ Amerihealth Caritas
- ☐ United Health Care

Medicaid Program: _____

Please describe your complaint(s) below:

Complaint:

(continued on the next page)

Complaint continued:

_____

Other Entities Contacted:

- ☐ Managed Care Organization (MCO)
- ☐ Department of Human Services
- ☐ Medicaid Provider: _____
- ☐ Case Manager: _____
- ☐ Other: _____

Would you like to be contacted by the Managed Care Ombudsman Program to discuss the complaint(s) indicated on this form?

- ☐ Yes
- ☐ No

The Managed Care Ombudsman Program will keep a confidential record of the complaint(s). By submitting the Medicaid Managed Care Complaint Form you are consenting for the Managed Care Ombudsman Program to contact the necessary parties to resolve the complaint(s) reported. The Managed Care Ombudsman Program reserves the right to contact the individual submitting the complaint and/or the Medicaid Managed Care Member as necessary.

Signature of Individual Submitting Complaint: _____

Signature of Medicaid Managed Care Member: _____

Please submit this form directly to:

Mail: Office of the State Long-Term Care Ombudsman
Attn: Managed Care Ombudsman
Jessie M. Parker Building
510 E 12th Street, Suite 2
Des Moines, IA 50313-9025

Fax: 515-725-3313

Email: ManagedCareOmbudsman@iowa.gov

*****Please note that this form is only intended for the Office of the State Long-Term Care Ombudsman and the Managed Care Ombudsman Program. If a complaint needs to be filed with the Managed Care Organization or the Department of Human Services, a separate form will need to be completed.***