CHRISTUS Health Plan

Grievance and Appeal Request Form

Please complete the form below with information about member's appeal/grievance.

Member Name:	
Member ID #:	Date of Birth:
Authorized Representative*:	
Phone Number:	
Address:	
Claim Number:	
Date(S) of Service:	
Name of Provider:	

Please explain your appeal, grievance, or complaint in this section. You can attach extra information to support your appeal, grievance, or complaint.

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*An Appointment of Representative (AOR) form or other equivalent written notice is required when someone files an appeal on behalf of a member. See link to CMS 1696 Appointment of Representative Form.

Appointment of Representative Form English

CHRISTUS Health Plan

Appointment of Representative Form Spanish

Signature of Member or Representative

Date

Relationship to Member (If Representative)

Mail this form to the following address for a timely appeal/grievance resolution:

CHRISTUS Health Plan Generations (HMO)

Appeal and Grievance Department
PO Box 169009
Irving, TX 75016
Fax# 1-866-416-2840

CHRISTUS Health Plan Generations (HMO) is a Medicare Advantage organization that is contracted with the Center for Medicare and Medicaid Services.

If you have any question please contact our Member Service Department at 1-844-282-3026, TTY 711.

October 1 – March 31:

• Live CSRs available seven days a week, from 8:00 a.m. to 8:00 p.m. in all time zones for the regions in which they operate

• Interactive voice response system or similar technologies for Thanksgiving and Christmas Day (messages must be returned within one (1) business day

April 1 – September 30:

• Live CSRs available Monday through Friday, from 8:00 a.m. to 8:00 p.m. in all time zones for the regions in which they operate

• Interactive voice response system or similar technologies for Saturdays, Sundays and Federal Holidays (messages must be returned within one (1) business day