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

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

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

CHRISTUS Health Plan Generations 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, 711 for TTY users. We are open Monday through Friday from 9 a.m. to 9 p.m. (Local Time). Our automated phone system will answer your call after 9 p.m. Monday through Friday, and on Saturdays, Sundays and some public holidays. Please leave your name and telephone number and we will call you back by the end of the next business day.