

# Grievance and Appeal Request Form



Please use this form to file an appeal (request for us to reconsider our decision) or grievance (complaint) related to your CHRISTUS Health Plan.

## Member Information

Member name \_\_\_\_\_

CHRISTUS Health Plan member ID number \_\_\_\_\_

Date of birth (MM/DD/YYYY) \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Authorized Representative\* \_\_\_\_\_

\*An Appointment of Representative form or written equivalent is required when someone files an appeal or grievance on behalf of a member. Link to the Appointment of Representative form is below.

[Appointment of Representative form - English](#)

[Appointment of Representative form - Spanish](#)

## Appeal / Grievance Information

Claim number \_\_\_\_\_

Date(s) of service \_\_\_\_\_

Name of provider \_\_\_\_\_

Please explain your appeal or grievance. You can attach extra information to support your appeal or grievance. \_\_\_\_\_

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\_\_\_\_\_  
Signature of Member or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Member (if Representative)

## **Grievance and Appeal Request Form**



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

**CHRISTUS Health Plan  
Appeal and Grievance Department  
PO Box 169009  
Irving, TX 75016**

**Fax# 1-866-416-2840**

If you have any questions, please contact our Member Services Department at 1.844.856.0826 (TTY 711) Monday - Friday 8:00 a.m. to 5:00 p.m. CST