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/YYY) _____

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 CMS-1696 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)

MC4913

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 1-844-282-3025 (TTY 711)
Monday - Friday 8:00 a.m. to 5:00 p.m. CST

CHRISTUS Health Plan is a licensed HMO in Texas. CHRISTUS Health Plan is also the sole owner of CHRISTUS Health Plan Louisiana which operates under the registered trade name of CHRISTUS Health Plan.