

MEDICAID AND NEVADA CHECK UP

MEMBER GRIEVANCE FORM

Member/Insured Name:			
Member Number:	Date of Birth:		
Description of the iss involved; name of fac		date(s), any known names of indiv	iduals
Signature		Date	
(If signed, a written res	ponse will be submitted to the	member/insured)	
WHEN COMPLETED, THIS	S FORM SHOULD BE SUBMITTED	го:	
COMPANY NAME:	Health Plan of Nevada		
DEPARTMENT:	Customer Response and Resolution Department		
MAILING ADDRESS:	PO Box 14865 Las Vegas, NV 89114-4865		

As always, the Member Services Department can be contacted directly at 1-800-962-8074.

HPN 2023 Section 23 Frequently Used Forms