Connect Nevada: Strengthening Youth, Empowering Families

Child/Youth/Adult Grievance & Complaint Form

Magellan Health, Inc. (Magellan) child, youth, adult, or their authorized representatives have the right to file a grievance & complaint. You will not be penalized for filing a grievance & complaint.

How to request a grievance & complaint:

1. Fill out and sign the form below. You may want to keep a copy for your records.
2. You can include, with this form, any additional documentation to support the grievance & complaint.
3. Fax, email, or mail your grievance & complaint to:
    a. **Email**: NevadaAppealsGrievances@magellanhealth.com
    b. **Mail**: Magellan Quality Department, P.O. Box 34028, Reno, NV 89533
    c. **Fax**: 1-888-656-5426
4. A grievance & complaint can also be requested verbally by calling Magellan at 1-833-396-4310 (TTY 711).
5. If additional information is needed, you will be contacted by a Magellan representative.
6. You will receive a written letter confirming receipt of your grievance within 5 business days.
7. Depending on the nature of the concern you've raised, you may expect to receive a resolution letter within 30 calendar days from the time Magellan acknowledges receipt of your grievance & complaint form.
8. Resolution letters for certain grievances & complaints may require additional time, particularly if the concern pertains to the quality of care you have received.
9. If you would like to have someone represent you during your grievance & complaint review, please fill out the Authorization to Release Protected Health Information (PHI) and include it with your submission.

Information about the complainant (You)		Your Name:	Your Email Address:	
Phone Number:	Can we leave you a voicemail? ☐ Yes or ☐ No	Date of Birth:	ID#:	
Street Address:		City:	State:	Zip Code:

Information about your grievance

Reason for your grievance:

Information about the Provider

(ONLY if Grievance is about a Provider)

Provider's Phone Number:	Provider's First Name:	Provider's Last Name:	
Provider's Street Address:	City:	State:	Zip Code:

Authorized Representative Information

You can ask someone to assist you with your grievance. If you decide to do this, please let us know below and fill out the Authorized for Use and Disclosure Form, then send it back to us with this grievance form. This way, we can share the same appeal information with that person as we do with you, unless you ask us to stop.

Authorized Representative Name & Relationship to you:	Phone Number:	E-mail Address:	
Street Address:	City:	State:	Zip Code:
Print Your Name & Sign (Child/Youth/Adult), Legal Guardian, or Parent if a minor, or Authorized Representative:		Date:	

Mail, Email, or Fax this Form, supporting documents, and the signed Authorized Use and Disclosure Form (if needed) to:

- Email: NevadaAppealsGrievances@magellanhealth.com
- Mail: Magellan Quality Department
  P.O. Box 34028, Reno, NV 89533
- Fax: 1-888-656-5426

Please call our Customer Experience Associates if you have questions or need help with completing this grievance form.

- 1-833-396-4310 (TTY 711)

Save Print Email to Quality Clear Form

Magellan HEALTH

Non-Discrimination Notice

Discrimination is against the law

Magellan* complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Magellan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Magellan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact your Magellan member service center 1-833-396-4310.

If you believe that Magellan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator, Corporate Compliance Department
8621 Robert Fulton Drive
Columbia MD 21046
Phone: 800-424-7721 (TTY 711)
compliance@magellanhealth.com

You can file a grievance by mail or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available athttps://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html

*Magellan refers to all applicable subsidiaries and affiliates of Magellan Health, Inc., including but not limited to Magellan Healthcare, Inc, and its subsidiaries.

Non-Discrimination Notice	
English	ATTENTION: If you speak english, language assistance services, free of charge, are available to you. Call 1-877-543-3875 (TTY: 1-800-456-4006).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-543-3875 (TTY: 1-800-456-4006).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-543-3875 (TTY: 1-800-456-4006)。
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-543-3875 (TTY: 1-800-456-4006).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-543-3875 (TTY: 800-456-4006)
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-543-3875 (TTY: 1-800-456-4006) 번으로 전화해 주십시오.
Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-877-543-3875 (TTY (հեռատիպ)՝ 1-800-456-4006):
Farsi	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-543-3875 (TTY: 1-800-456-4006) تماس بگیرید.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-543-3875 (TTY: 1-800-456-4006).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-543-3875 (TTY: 1-800-456-4006)まで、お電話にてご連絡ください。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-543-3875 (رقم هاتف الصم والبكم: 1-800-456-4006).
Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-877-543-3875 (TTY: 1-800-456-4006) 'ਤੇ ਕਾਲ ਕਰੋ।
Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-877-543-3875 (TTY: 1-800-456-4006)។
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-543-3875 (TTY: 1-800-456-4006).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-543-3875 (TTY: 1-800-456-4006) पर कॉल करें।
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-543-3875 (TTY: 1-800-456-4006).