



Complete and mail or fax to:  
111 E. Capital St., Suite 500 / Jackson, Mississippi / 39201  
Attention: Provider Complaints/Grievances  
Fax: 1-877-851-3995

**Provider Complaint/Grievance Form**

Physician / Provider Name: \_\_\_\_\_  
Respond to attention of: \_\_\_\_\_

Form completed by (check one):  Provider  Provider Office Staff

Phone Number: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
E-mail address: \_\_\_\_\_ Fax number: \_\_\_\_\_  
Are you a contracted provider? (check one):  Yes  No  
NPI#: \_\_\_\_\_ Medicaid ID# \_\_\_\_\_  
Provider ID# \_\_\_\_\_ Tax ID# \_\_\_\_\_

**Complaint type (choose):**

- |                                     |   |
|-------------------------------------|---|
| Attitude and Service of Health Plan | Claims Processing – Plan Administration |
| Claims Processing – Misc.           | Complaint Process                       |
| Marketing                           | Physician/Provider Contracts            |
| Plan Administration – Misc.         | UR/UM – Case Management                 |
| UR/UM – Non Covered Benefit         | UR/UM – Prior Authorization             |
| UR/UM – Late Notification           | UR/UM – Misc.                           |
| Other                               |   |

If "Other" please specify: \_\_\_\_\_

**Complaint Details**

Please describe complaint:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How can Magnolia fairly resolve your issue:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Member Information (if Applicable)**

Patient's Name: \_\_\_\_\_ Patient's Medicaid #: \_\_\_\_\_  
Claim # (if applicable): \_\_\_\_\_ Date(s) of Service: \_\_\_\_\_

*For Administrative USE ONLY:*

Complaint #: \_\_\_\_\_

Date Received: \_\_\_\_\_