Complete and mail or fax to:
111 E. Capital St., Suite 500 / Jackson, Mississippi / 39201
Attention: Provider Complaints/Grievances

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 – Misc.
Marketing
Plan Administration – Misc.
UR/UM – Non Covered Benefit
UR/UM – Late Notification
Other
Claims Processing – Plan Administration
Complaint Process
Physician/Provider Contracts
UR/UM – Case Management
UR/UM – Prior Authorization
UR/UM – Misc.

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:* _____