Complete and mail or fax to:
111 E. Capital St., Suite 500 / Jackson, Mississippi / 39201
Attention: Provider Complaints/Grievances
Fax: 1-866-480-3227

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:

____
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____
____

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:* ___________________________