



magnolia health™

Mississippi Children's Health Insurance Program

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 – 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: _____