Michigan Internal Appeal Form

Call 888-437-0606, Monday – Friday from 8:00 a.m. to 6:00 p.m. to speak with one of our representatives. We can answer any questions you may have.

If you or someone acting on your behalf wishes to file an appeal, please complete this form and mail to:

Meridian
ATTN: Appeals Department
P.O. Box 10353
Van Nuys, CA 91410-0353

Meridian will mail the final appeal decision within 10 days for CSHCS members. All other members will receive the final appeal decision by mail within 30 days.

Please print the following information:

Member Name (Last, First, Middle Initial) Male/Female Date of Birth

Address City, State, Zip

Home/Work/Cell Phone number Medicaid ID #

Date: _____ Member's Signature: _____

Authorized Representative: You may authorize in writing any person such as your doctor, lawyer, friend, parent or spouse to represent you in the internal grievance/appeal process. Complete the information below to authorize a representative other than yourself.

Name: _____ Telephone #: _____

Relationship to Member: _____

Address: _____

City: _____ State: _____ Zip: _____

Authorized Representative Signature: _____

Please turn over to complete form.

Please write a description of the appeal with as much detail as possible. Attach extra pages, if needed.