EVOLENT HEALTH Appeal or Grievance Member Services Intake Request

Please fax to Evolent Appeals and Grievance Dept : 1-855-435-8762

Call Receipt
Cut Log: Click here to enter text.
Date: Click here to enter a date.
Time of Call: Click here to enter text.

Member Services Representative
Name: Click here to enter text.
Phone: Click here to enter text.

Caller Information		
Caller Name: Click here to enter text.	Phone: Click here to enter text.	Relationship to Member: Click here to enter text.
Address (N/A if caller is member): Click here to enter text.		
City: Click here to enter text.	State: Click here to enter text.	Zip: Click here to enter text.
Member Name: Click here to enter text.	Member Phone: Click here to enter text.	
Member ID: Click here to enter text.	Plan Name: Click here to enter text.	
AOR or POA on file: Yes ☐ No ☐ NA ☐	Date AOR received: Click here to enter text.	

Details of Call			
Expedited Request ☐	Standard Request ☐	Appeal ☐	Grievance ☐
Date(s) of Service (if applicable): Click here to enter a date.			
Provider Name (if applicable): Click here to enter text.			
Vendor issue: N/A ☐ Avesis ☐ Magellan ☐ Optum ☐			
Detailed account of Caller's issues: Click here to enter text.			
Verified accuracy of request and intent of caller (Insert initials here) : Click here to enter text.			