arkansas total care

Grievance, Appeal, Concern or Recommendation Form

Please complete this form to file a grievance, appeal, concern or recommendation. You do not have to fill out this form. Instead, you may write a letter with the information required below. You can mail the completed form or your letter to:

Arkansas Total Care
ATTN: Appeal Department
PO Box 25010
Little Rock, AR 72221
Phone: 1-866-282-6280 TDD/TTY: 711
Fax 1-866-811-3255

Member's Name:	Member ID Number:	
Street Address:		
City:	State:	Zip:
Tracking Number (if applicable. Found in upper left hand corner of denial letter):		
Please include any additional information to support the grievance, appeal, concern or recommendation (or attach):		
Member or Representative:	Daytime Phone #:	Date:

You must file an appeal within 60 calendar days of the date of the denial letter.

© 2018 Arkansas Total Care, Inc. All rights reserved.
ARTC18-H-084