PROVIDER COMPLAINT FORM

Date Rec'd: Taken By:

Provider Name: Provider ID#:

Address: Phone#:

Complainant:

Type of Contact: ___ Letter ___ Telephone ___ In Person Documentation Attached? ___ Yes ___ No

COMPLAINT TYPE:

___ Member Problem
___ Attitude/Personality Conflict
___ Billing Problem
___ Other _____

___ Communication
___ Multiple Complaints
___ Disagree with Policy
___ Claims Payment Problem

___ Referral Problem
___ Unhappy with Health Plan
___ Phone Access
___ FOR INFORMATION ONLY (FYI)

If complaint is against a member, list the member's Name/ID#:

NATURE OF COMPLAINT: _____

ACTIONS TAKEN: _____

DISTRIBUTION/DATE:

___ Plan Nurse _____
___ UR/QA Director _____
___ Other _____

___ Grievance Dept. _____
___ Medical Director _____
___ Other _____

___ Claims Research _____
___ UM/QI Director _____
___ Other _____