

PLEASE RETURN FOR PROMPT RESOLUTION OF YOUR COMPLAINT IN THE ENCLOSED SELF-ADDRESSED STAMPED ENVELOPE.

COMMUNITY FIRST HEALTH PLANS, INC. COMPLAINT FORM

Subscriber Name: _____ Group ID: _____ Date: _____

Member Name: _____ Relationship to Subscriber: _____

Phone (Home): _____ (Business): _____

Address: _____

City: _____ State: _____ Zip: _____

Type of Coverage: (Check one)

STAR Program Commercial CHIP

Company Name: _____

Primary Care Physician: _____ Center Name (if applicable): _____

Physician Involved: _____

Type of Complaint: (Check one)

Quality of Care or Service Attitude/Enrollee Services Accessibility/Availability/Enrollee Services
 Plan Administration Enrollment/Eligibility Claims
 Health Promotion & Wellness Benefit Denial or Limitation

Other (Please Explain)

Description of Complaint

1. Please explain your complaint (use additional sheets if necessary) _____

2. What date was service provided? _____

By whom (e.g., physician/hospital) _____

3. Have you discussed this complaint with any company/staff personnel? Yes No

If yes, with whom? (Give names) 1. _____

2. _____

3. _____

If yes, what was said?

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4. If your complaint involves the denial of a claim payment, have you paid for this service?
 Yes No if yes, how much? \$ _____ Whom did you pay? _____
Can you provide proof of payment? Yes No

If your complaint is a denial of service, have you received this service out of the HMO?

By whom? _____

If no, what is the service needed? _____

5. How would you like your complaint resolved? _____

6. Other comments: _____

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

FOR STAFF USE ONLY

Date of Receipt in Member Services Resolution Unit

Staff Receiving Complaint