

Complaint and appeal form



NAME OF PERSON FILING COMPLAINT		TELEPHONE NO.		
ADDRESS		CITY	STATE	ZIP
MEMBER NAME	PATIENT NAME		MEMBER ID NO.	
NAME OF PROVIDER INVOLVED	ADDRESS		TELEPHONE NO.	
NAME OF PROVIDER INVOLVED	ADDRESS		TELEPHONE NO.	
DATE(S) OF SERVICE				

Please write your complaint or appeal in the space below and on the back of this page. Attach additional pages if needed. You may include any document such as explanation of benefits (EOBs), correspondence, or invoices which will help us investigate your complaint or appeal. Please sign and date this form.

I certify that the above information is accurate and complete to the best of my knowledge.

SIGNATURE X	DATE
----------------	------

Ready to submit? Mail form to OHSU Health Services, Attn: Appeal Unit, P.O. Box 40384, Portland, OR 97240 or fax to 503-412-4003.

Questions? Contact a customer service representative at 844-827-6572.