



# Member Grievance/Complaint Form

Control No.

Member No.

Name of Subscriber: \_\_\_\_\_ Date of Call/Visit \_\_\_\_\_

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone/Fax: \_\_\_\_\_

### Type of Complaint/Inquiry

- |   |  |
|---|--|
| <input type="checkbox"/> Claims/Coverage Issue      | <input type="checkbox"/> Premiums/Payment      |
| <input type="checkbox"/> Provider/Physician Service | <input type="checkbox"/> Benefits              |
| <input type="checkbox"/> Eligibility/Enrollment     | <input type="checkbox"/> Quality of care issue |
| <input type="checkbox"/> Customer Service           | <input type="checkbox"/> Other: _____          |

### Explanation of Complaint/Inquiry:

(Please state your complaint, concerns, grievance or inquiry fully. You must be specific. You may attach additional pages if necessary)

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### For NetCare Use Only

#### Health Plan Action:

1. The complaint/inquiry was forwarded to the following department for follow-up:

- |  |   |
|--|---|
| <input type="checkbox"/> Claim Management      | <input type="checkbox"/> Marketing          |
| <input type="checkbox"/> Utilization Review    | <input type="checkbox"/> Provider Relations |
| <input type="checkbox"/> Health Administration | <input type="checkbox"/> Accounting         |

Member Representative: \_\_\_\_\_

2. Status of complaint/Inquiry:

- |  |
|--|
| <input type="checkbox"/> Resolved satisfactorily             |
| <input type="checkbox"/> Pending information                 |
| <input type="checkbox"/> Unresolved                          |
| <input type="checkbox"/> Follow-up required (please explain) |

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