

MEMBER COMPLAINT/GRIEVANCE APPEAL FORM

Member Information:

Name of Member involved in Complaint: _____ CIN #: _____

Head of Household/Guardian: _____ File #: _____

Address: _____ Telephone #: _____

Explanation of Incident/Complaint:

Reason(s) for Complaint Appeal:

How would you like your complaint appeal resolved/determined:

Signature of Complainant or Designee: _____ Date: _____

Please return this form to: **Neighborhood Health Providers**
4944 Parkway Plaza Blvd, Suite 110
Charlotte, NC 28217
Attn: Member Services Center or fax to 800-334-4195

You have no less than sixty (60) business days from the date you received the resolution letter to file an appeal. For assistance in completing this form, please call our Member Services Department at 1-800-826-6240.

For Official Use Only — Please do not write below this line

Receipt of the Complaint Appeal (Date): _____ Received by: _____

Clinical Complaint No Yes If yes, refer to: _____ Date referred: _____

Reviewed and approved by (Signature): _____ Date: _____