

MEMBER COMPLAINT/GRIEVANCE FORM

Member Information:

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

Head of Household/Guardian: _____ File #: _____

Address: _____ Telephone #: _____

Explanation of Incident/Complaint:

Reason(s) for Complaint:

How would you like your complaint 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 800-338-4195

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

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

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

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