



PROVIDER COMPLAINT FORM

Provider Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Product Type: STAR Program Commercial CHIP EPO PPO

Type of Complaint:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Physician Related | <input type="checkbox"/> Hospital Related | <input type="checkbox"/> Claims Related | <input type="checkbox"/> Access to Care |
| <input type="checkbox"/> Denied/Day Claim | <input type="checkbox"/> Enrollment Related | <input type="checkbox"/> Provider Education | <input type="checkbox"/> Health Plan |
| <input type="checkbox"/> Personnel Problems | <input type="checkbox"/> Termination | <input type="checkbox"/> Telephone Problems | <input type="checkbox"/> Referral Procedure |

Other (Please explain) _____

Description of Complaint:

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

2. Date of Incidence: _____

3. Have you discussed this complaint with any Community First Health Plans personnel: Yes No

If yes, with whom: _____

What was discussed: _____

4. How would you like your complaint resolved? _____

4. Other comments _____

This form must be completed and returned to the below address in order for your complaint to be reviewed and resolved:

Community First Health Plans
Attn: Network Management
122348 Silicon Drive, Ste. 100
San Antonio, TX 78249

Signature: _____ Date: _____

Printed Name: _____