## OKLAHOMA HEALTH CARE AUTHORITY MEMBER COMPLAINT/GRIEVANCE FORM

Any problem or complaint that you may have concerning your health care is important to us. In order to initiate the Appeals Process, you must fill out this form and return it to the Oklahoma Health Care Authority within twenty days of the triggering event. Failure to provide all of the information will result in a slower response from the OHCA. Any questions about eligibility must be handled by the Department of Human Services. Please give a complete narrative explanation of the problem you have encountered. Include the names of OHCA personnel you have dealt with, and the dates that specific events occurred. Use additional paper if necessary. Attach copies of any supporting documentation you would like to be considered.

Member Information:		
Name:		Case No
Mailing Address:		
	NUMBER	STREET
CITY	STATE	ZIP CODE
Phone Number: ()		
Date of Adverse Action:		
Authorized Representat	tive Information	(If any):
Name:		
Mailing Address:		
	NUMBER	STREET
CITY	STATE	ZIP CODE
Phone Number: ()		
would like to make a co	mplaint about the	e following individual or organization
Name:		
Location:		
Number		Street
City	State	Zip Code
Phone Number:_()		

and whenever possible, give the date	in the space below. Be as specific as possible e(s) that the event occurred.
[If you need more space, use anoth	her sheet of paper]
Have you told the individual or organif so, what happened?	nization that you have a problem or complaint?
What would you like the Oklahoma H	lealth Care Authority to do about this problem?
SIGNATURE	DATE
PLEASE SEND THIS FORM TO:	Oklahoma Health Care Authority Grievance Docket Clerk Legal Division P.O. Drawer 18497 Oklahoma City, Oklahoma 73154-0497

OHCA Fax Number is (405) 530-3455 OHCA Docket Clerk Telephone Number is (405) 522-7217