



# Provider Grievance Form

Provider Name:	Date of Complaint:
Address:	Complaint Filed by:
	Member Information (if applicable):
Telephone:	Member Name:
Fax:	ID#: <span style="float: right;">DOB:</span>

Description of the Grievance/Complaint:

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Action Requested by Provider:

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Supporting Documentation:

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Provider or Representative Signature:	Date:
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Submit form to Provider Relations, PHC California, 1001 N. Martel Ave, Los Angeles, CA 90046, or fax to Provider Relations at (888) 235-7695.