Provider Grievance Form

Provider Name:	Date of Complaint:
Address:	Complaint Filed by:
	Member Information (if applicable):
	Member Name:
Telephone:	ID#: DOB:
Fax:	

Description of the Grievance/Complaint:

Action Requested by Provider:

Supporting Documentation:

Provider or Representative Signature:	Date:

Submit form to Provider Relations, Positive Healthcare Partners, 1001 N. Martel Ave, Los Angeles, CA 90046, or fax to Provider Relations at (888) 235-7695.