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 via mail or fax: PHC-CA Provider Relations & Contracting, 6255 Sunset Blvd, 19th Floor, Los Angeles, CA 90028 or (888) 235-7695.