MEMBER COMPLAINT FORM

We are extremely interested in addressing your complaint. This form is used to gather important information necessary to research this complaint. Please provide as much information as possible.

Member Name: _____ ID No: _____

Date of the Incident(s): _____

If the incident(s) involved a physician or other provider or service, please list the name(s) of those involved:

_____

_____

_____

If the incident(s) involved an employee of Blue Cross & Blue Shield of Rhode Island, please list the name of the employee involved:

_____

Briefly describe the incident(s) causing this complaint filing:

_____

_____

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Mail To: Blue Cross & Blue Shield of Rhode Island
Attention: Grievance & Appeals Unit
444 Westminster Street
Providence, RI 02903-3279

Disclosure Statement:
By signing this form, you are allowing us to use your name if we need to contact individuals for information. If you do not sign this form, our ability to fully review your complaint may be affected.

Disclosure Accepted ❑ Disclosure Denied ❑
Please check one of the boxes above.

_____
Member Signature

_____
Date

Blue Cross Blue Shield of Rhode Island
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www.BCBSRI.com