## MEMBER COMPLAINT FORM

CalOptima Grievance and Appeals Resolution Services 505 City Parkway West Orange, CA 92868



For Questions Call CalOptima Customer Services 1-888-587-8088

MEMBER IN	NFORMATION	ON				
Member 's First Name		M.I.	Last Name		Member ID Card No:	
Health Network		Person Making Complaint	į.			Date
Address	Apt. #	City	Zip		Phone [ ]	
NATURE OI	F COMPLAI	NT				
Please Check:  Problem with Doctor or Staff		☐ Problem Getting Appointment(s) ☐ Bill Received for M			ledical Services	
_						
Problem Getting a Referral		Problem Getting Medicine/Prescription Problem with Medical Care				
Office/Facility	Problem	Other		-		
Person Completi	ing this Form, Sta	te Relationship to Membe	r:			Use second sheet if required
Member/Self	Parent	Grandparent	Authorized R	epresentative	Other	
Provider	☐ CalOptima	Health Network				
<u>X</u>			<u>X</u>	-		
	Print Name				Title (If App	icable)
X Signatur	re of Party Comple	ting this Form	<u>X</u>		Date	
DOCTOR IN	NFORMATIC	)N			Date	
Doctor Name			Date of	Last Visit		
Address						
City			Phone [			