



## MEMBER COMPLAINT FORM

If you wish to file a formal complaint regarding the care or service which you have received from CDPHP® or any of our participating providers, please complete this form and return it to our Quality Enhancement Department. The information you provide will assist us in investigating your concerns.

### Member Information

Name of Member Involved: \_\_\_\_\_

Member ID: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Name of Person Filing Complaint (if different): \_\_\_\_\_

### Provider Information

Is your complaint regarding a particular provider or CDPHP service? Please check the appropriate box.

Provider (MD, Pharmacy, Laboratory, Vendor)       CDPHP

Provider Name: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Location: \_\_\_\_\_

### Primary Complaint: *Please complete the following.*

Briefly describe the reason for seeking medical care or service from CDPHP: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

