MEMBER GRIEVANCE FORM

Member's Name _____ Member's Date of Birth _____

Member's ID Number _____ Member's Medical Records # _____

Name of member's Designated Personal Representative/Guardian
(please see DPR form/Attachment C at the end of the handbook)

_____

Date of Incident _____

Contact Phone Number _____

Person(s) or Provider(s) Involved _____

_____

Describe what happened:

_____

_____

_____

_____

_____

_____

Signature _____
Of Member or Member's Designated Representative/Guardian

Date _____

Please send to: **Colorado Choice Health Plans**
Attn: Grievance and Appeals Department
700 Main Street, Suite 100
Alamosa, CO 81101
Phone: 719-589-3696