

**Physician/Provider Grievance Form**

Fax completed form to 1-866-387-2968.

**Provider Information**

Medicaid                       SCHIP

Date: \_\_\_\_\_ Primary Care Provider Site Number: \_\_\_\_\_

Provider Name: \_\_\_\_\_ License Number: \_\_\_\_\_

Tax ID Number: \_\_\_\_\_ Are you part of the BlueChoice HealthPlan network?     Yes  No

Address: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Information about the Grievance**

This information is part of the permanent record. Write clearly and legibly. Use more sheets of paper if necessary.

Policy Issue     Service Issue     Medical Group Issue     Quality Issue     Other

Member Name: \_\_\_\_\_ Member ID Number: \_\_\_\_\_

Date of Incident: \_\_\_\_\_

Describe What Happened: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Provider: \_\_\_\_\_ Date: \_\_\_\_\_