Provider Complaint Form

- ❑ 'Ohana Health Plan - Medicaid
- ❑ 'Ohana Health Plan - Medicare

Request Date: ____________

Provider Information

Name: ______________________________

Address: ______________________________

City: ______________________________

Telephone: ______________________________

Fax: ______________________________

Contact Person: ______________________________

Patient Information

❑ **Multiple Members**
(List on separate sheet)

Name: ______________________________

ID Number: ______________________________

Date of Birth: ______________________________

Information on Service Provided

Date(s) of Service: ______________________________

Place of Service: ______________________________

√ Complaint Reason

__ 'Ohana Administration
__ Member Behavior
__ Health Care Delivery
__ Provider Reimbursement
__ Contracting

Explanation of Issue(s)

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Fill out the form completely and keep a copy for your records. Send this form with all documentation to support the complaint to 'Ohana Health Plan, Attn: *Grievance Department,* **P.O. Box 31384, Tampa, FL 33631-3384 or Fax to: 1-866-388-1769**. Your request will be processed once all necessary documentation is received and you will be notified of the outcome.

***Failure to submit supporting documentation may delay our response to your complaint.**