MEMBER COMPLAINT FORM

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

Medi-Cal CalOptima A Public Agency Better. Together.

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

MEMBER INFORMATION

Member 's First Name	M.I.	Last Name	Member ID Card No:
Health Network	Person Making Complaint		Date

Address Apt. # City Zip Phone [ ]

NATURE OF COMPLAINT

Please Check:

☐ Problem with Doctor or Staff ☐ Problem Getting Appointment(s) ☐ Bill Received for Medical Services

☐ Problem Getting a Referral ☐ Problem Getting Medicine/Prescription ☐ Problem with Medical Care

☐ Office/Facility Problem ☐ Other _____ ☐ Appeal

Person Completing this Form, State Relationship to Member: **Use second sheet if required**

☐ Member/Self ☐ Parent ☐ Grandparent ☐ Authorized Representative ☐ Other _____
☐ Provider ☐ CalOptima ☐ Health Network

X _____ X _____
Print Name Title (If Applicable)

X _____ X _____
Signature of Party Completing this Form Date

DOCTOR INFORMATION

Doctor Name	Date of Last Visit
Address	
City	Phone [ ]