MEMBER COMPLAINT FORM

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

CalOptima Health Customer Service
1-888-587-8088 (TTY **711**)

MEMBER INFORMATION

Member's First Name	M.I.	Last Name	Member ID Card #:
Health Network	Person Making Complaint		Date

Address Apt. # City ZIP Phone ( )

NATURE OF COMPLAINT

Please check:

- ☐ Problem with doctor or staff
- ☐ Problem getting a referral
- ☐ Office or facility problem
- ☐ Problem getting appointment(s)
- ☐ Problem getting medicine or prescription
- ☐ Other: _____
- ☐ Bill received for medical services
- ☐ Problem with medical care
- ☐ Received a denial

Additional information (**use second sheet if needed**):

Is the person completing this form the member? ☐ Yes ☐ No

If you are not the member, are you the member's Authorized Representative? ☐ Yes ☐ No

Please state your relationship to the member:

☐ Spouse ☐ Parent ☐ Grandparent ☐ Sibling ☐ Friend ☐ Guardian ☐ Child (18+)

☐ Provider ☐ CalOptima Health Representative ☐ Health Network Representative ☐ Other

_____ Print Name

_____ Title (if applicable)

_____ Signature of Person Completing This Form

_____ Date

DOCTOR INFORMATION

Doctor's Name	Date of Last Visit
Address	
City	Phone ( )