HCO Enrollee Grievance Form

Attention: Complaints may be filed by any person who is reconciling a prompt payment grievance. Any person who files such a grievance under false pretenses may be subject to legal action.

Please Print Clearly:

First	**M.I.**	**Last**	**Date**
Address	**City**	**State**	**Zip Code**
	E-mail Address		
Your SS#	**Your Date of Birth**		

Name of Insurance Company or Payer

Address of Insurance Company or Payer

Claim Number

Type of Coverage – Health or PPO__________ **Workers' Compensation**________________

Type of complaint: Please check all that apply:

- ☐ Administrative
- ☐ Eligibility
- ☐ NCM/Utilization
- ☐ Other
- ☐ Referral/Authorization
- ☐ Access to care
- ☐ Scheduling time
- ☐ Courtesy of HCO personnel
- ☐ Other

Have you previously discussed this matter with Net-Work HCO personnel?
If yes, then with whom and when?

Please state your complaint (you may attach supporting documents and use Page 2 if necessary.)
For prompt handling of complaints you may also attach a copy of your bills including dates of service. Pleases provide as much detailed information about your complaint including copies of your correspondence or other written materials regarding your complaint.

Please Submit to:
RN, Case Manager –
Net-Work HCO
3373 Cerritos Avenue
Los Alamitos, CA 90720
(562) 546-0035 phone and fax (562) 546-0037

rn@networkHCO.com

For additional information please visit:
www.networkHCO.com