



HCO Provider 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:

Provider Name	Medical Group (if applicable)	Date
Attention	Phone	Fax
Address	City	State
	E-mail Address	

Patient Name (one patient per form)

Patient SS#	Patient Date of Birth
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Name of Insurance Company or Payer

Address of Insurance Company or Payer

Claim Number

Type of Coverage – Health or PPO _____ Workers’ Compensation _____

**Have you previously discussed this matter with Harbor personnel?
If yes, then with whom and when?**

For prompt handling of complaints you may also attach a copy of the patients uniform bills including dates of service for bill in question including copies of any medical reports or supporting documentation:

**UB-92
HCFA – 1500 Physicians and all other providers
J510, J511, or J512 ADA Form – Dentist**

Please state your complaint (you may attach supporting documents and use Page 2 if necessary):

Type of complaint: Please check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Administrative
<input type="checkbox"/> Eligibility
<input type="checkbox"/> NCM/Utilization
<input type="checkbox"/> Other | <input type="checkbox"/> Referral/Authorization
<input type="checkbox"/> Access to care
<input type="checkbox"/> Scheduling time
<input type="checkbox"/> Courtesy of HCO personnel
<input type="checkbox"/> Other |
|---|--|



HCO Provider Prompt Pay / 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:

Provider Name	Medical Group (if applicable)	Date
Attention	Phone	Fax
Address	City	State
	E-mail Address	

Patient Name (one patient per form)

Patient SS#	Patient Date of Birth
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Name of Insurance Company or Payer

Address of Insurance Company or Payer

Claim Number

Type of Coverage – Health or PPO _____ Workers’ Compensation _____

Have you previously discussed this matter with Harbor personnel? If yes, then with whom and when?

For prompt handling of complaints you may also attach a copy of the patients uniform bills including dates of service for bill in question:

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HCFA – 1500 Physicians and all other providers
J510, J511, or J512 ADA Form – Dentist

Please state your complaint (you may attach supporting documents and use Page 2 if necessary):

Dates of service for bill in question:

