COMMUNITY FIRST HEALTH PLANS

PROVIDER COMPLAINT FORM

Provider Name: ______________________________

Address: ______________________ City: ______________ State: ________ Zip: ________

Phone Number: ______________________ Fax Number: ______________________

Product Type: ☐ STAR Program ☐ Commercial ☐ CHIP ☐ EPO ☐ PPO

Type of Complaint:

☐ Physician Related ☐ Hospital Related ☐ Claims Related ☐ Access to Care
☐ Denied/Day Claim ☐ Enrollment Related ☐ Provider Education ☐ Health Plan
☐ Personnel Problems ☐ Termination ☐ Telephone Problems ☐ Referral Procedure

☐ Other (Please explain) ______________________________

Description of Complaint:

1. Please explain your complaint (use additional sheets if necessary.) ______________________________

2. Date of Incidence: ______________________

3. Have you discussed this complaint with any Community First Health Plans personnel: ☐ Yes ☐ No

   If yes, with whom: ______________________________

   What was discussed: ______________________________

4. How would you like your complaint resolved? ______________________________

4. Other comments ______________________________

This form must be completed and returned to the below address in order for your complaint to be reviewed and resolved:

Community First Health Plans
Attn: Network Management
122348 Silicon Drive, Ste. 100
San Antonio, TX 78249

Signature: ______________________________ Date: ______________

Printed Name: ______________________________

12238 Silicon Drive, Ste. 100
San Antonio, TX 78249
www.cfhp.com | (210) 227-2347