PROVIDER COMPLAINT FORM

Provider Name:

Address: City: State: Zip:

Phone Number: Fax Number:

TIN: NPI:

Product Type: STAR Medicaid STAR Kids CHIP Commercial STAR+PLUS HIE Medicare Advantage University Family Care Plan

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?

5. Other Comments:

This form must be completed and emailed to ProviderRelations@cfhp.com or returned to the below address in order for your complaint to be reviewed and resolved:

Community First Health Plans
Attn: Network Management
12238 Silicon Drive, Ste. 100
San Antonio, TX 78249

Signature: Date:

Printed Name: