



Community Health, Inc.

ODS GRIEVANCE AND APPEAL FORM

OREGON HEALTH PLAN			
Name Of Person Filing Complaint		Telephone	
Address	City	State	Zip
Patient Name	Client ID	Group ID	
Name of Provider Involved		Telephone	
Address	City	State	Zip
Name of Provider Involved		Telephone	
Address	City	State	Zip
Date(s) of Service			

Please type or write your grievance or appeal. Attach additional pages if needed.
