



HEALTHCARE COOPERATIVE

Grievance Filing Information

Please fill out this form completely and return to:

MAIL: Common Ground Healthcare Cooperative
120 Bishop's Way, Suite 150 Brookfield,
WI 53005
FAX: 262-754-9690

A grievance is an expression of dissatisfaction with our services or any clinical care provided that we receive in writing. A grievance can be filed by a member or someone acting on behalf of a member about any aspect of care or services, except for an adverse claims determination or denial of coverage as described in the "appeals" section of your Member Handbook. Grievances can include but are not limited to written complaints about: Quality of care, access to care, attitude and service, billing and financial issues, and quality of practitioner office sites

Grievances are evaluated for clinical urgency. A member of our Grievance Department will send the member a written acknowledgement letter within five business days of receipt of this form.

Grievances are investigated including any aspect of clinical care involved. This may include, but is not limited to, a request for medical records or a provider response. The Health Services Department will resolve the grievance within 30 days unless an extension is needed.

If an extension is needed, the member is informed that an additional time (up to 14 days) is needed for a resolution. The member is also informed about the expected date of resolution. Once the issue is resolved, a closure letter is sent to the member which includes a description of the outcome of the grievance.

I. Subscriber/Member Information

FIRST NAME	M.I.	LAST NAME	DATE OF BIRTH / /	
HOME ADDRESS – STREET		CITY	STATE	ZIP CODE
PRIMARY PHONE (include area code)	SECONDARY PHONE (include area code)	NEW ADDRESS? <input type="radio"/> YES <input type="radio"/> NO	SUBSCRIBER ID NUMBER	

II. Description of Dissatisfaction

Describe in detail the nature of the facts and circumstances (including dates if available) that explain your dissatisfaction. NOTE: Attach separate sheet of paper if needed.

III. Possible Action

Please include what actions CGHC could take in order to resolve your dissatisfaction.

SIGNATURE OF MEMBER FILING GRIEVANCE		DATE
SIGNATURE OF PERSON COMPLETING FORM (IF SOMEONE OTHER THAN MEMBER)		DATE