MEMBER GRIEVANCE FORM

A grievance is a written or verbal expression of the dissatisfaction regarding VBA and/or a doctor, including quality of care concerns, and includes a complaint, dispute and/or request for consideration.

Policyholder's Information

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Date of Birth: _____ **ID Number or Last Four SSN:** _____

Address: _____

Email: _____ **Daytime Phone:** _____

Name of Policyholder Group: _____ **Group Number:** _____

Member (Patient) Information

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Doctor's Information

Name: _____ **Phone:** _____

Address of Service: _____

Date of Service: _____ **May we contact your doctor regarding this grievance?** ☐ **Yes** ☐ **No**

Grievance Comments: Please include the details leading to your grievance, name(s) of others involved, and any related documents/receipts. Attach additional sheets if necessary.

Signature of Policyholder: _____ **Date:** _____

If you are completing this form on behalf of the patient, please provide the following information:

Name: _____ **Relationship:** _____

Address: _____

Daytime Phone: _____ **Email:** _____

RETURN COMPLETED FORM TO:

VBA
Attn: Grievance Department
400 Lydia Street, Suite 300
Carnegie, PA 15106
Fax: 412-881-4898