



<b>OREGON HEALTH PLAN</b>			
<b>Name of Person Filing Compliant</b>		<b>Telephone</b>	
<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Patient Name</b>	<b>Client ID</b>	<b>Group ID</b>	
<b>Name of Provider Involved</b>		<b>Telephone</b>	
<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Name of Provider Involved</b>		<b>Telephone</b>	
<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Date(s) of Service</b>			

Please type or write your complaint. Attach additional pages if needed.

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