

Network Complaint / Appeal Form

Injured Worker	Injured worker name		
	Address		
	Insurance carrier & employer		
	Claim number		
	Date of injury		
	Current treating doctor		

Complainant	Complainant name			
	Complainant address			
	Phone/fax numbers			
	Please select a complaint category	<input type="checkbox"/> Quality of care or services <input type="checkbox"/> Accessibility and availability of services or providers <input type="checkbox"/> Utilization review and retrospective review <input type="checkbox"/> Complaint procedures <input type="checkbox"/> Healthcare provider contracts <input type="checkbox"/> Bill payment <input type="checkbox"/> Fee disputes <input type="checkbox"/> Denial of treating doctor change or specialist referral <input type="checkbox"/> Miscellaneous		
	Please explain the circumstances of the complaint. Please provide details. :			_____
	Please attach any additional documentation and/or medical records to support this complaint.			_____
Complainant Signature		Date		
<p>Complaints should be submitted to the CompKey Plus Network Coordinator at the above address, fax, phone or email.</p>				

The Network shall acknowledge receipt of the complaint within seven calendar days of receipt. The network shall investigate the circumstances of each complaint and appeal received and shall issue a resolution letter not later than the 30th calendar day after the network receives the written complaint.