Vision Plan of America

Member Grievance Form/Worksheet

Received by (Initial): _____ Time & Date Received: _____

PATIENT'S NAME:	MEMBER NUMBER:	DATE OF SERVICE:
MEMBER NAME (IF DIFFERENT FROM PATIENT'S NAME):	PLAN TYPE:	BIRTHDATE:
GROUP NAME/GROUP # (If Applicable):		
HOME TELEPHONE #:	WORK TELEPHONE #:	
STREET ADDRESS:	CITY, STATE, ZIP	
PROVIDER NAME:		FACILITY#:
PROVIDER TELEPHONE #:		GRIEVANCE TYPE:

Grievance Summary (continued on reverse or attached separate page if necessary)

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FOR OFFICE USE ONLY

Date 1st letter sent: _____

Result
Date of Resolution:_____

To be expedited:
Yes_____ No _____

Disposition (Plan/Member): _____

Grievance Type

1) Plan Complaints:
- a) Communication
- b) Eligibility
- c) Enrollment
- d) Explanation of Benefits
- e) Premiums
- f) Language
- g) Medical Necessity
- h) Other _____

2) Provider Complaints:
- a) Quality of Care
- b) Communication in office
- c) Service
- d) Access
- e) Finances
- f) Language
- g) Medical Necessity
- h) Other _____

Conclusion: _____

_____

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_____

Please complete and return to:
Vision Plan of America ~ 3250 Wilshire Blvd 31610 ~ Los Angeles CA, 90010
fax (213) 384-0084 ~ phone (213) 384-2600 ~ toll free (800) 400-4VPA (4872) ~ email info@visionplanofamerrica.com

Detailed Grievance Summary Continued