OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
Health Resources Development Service
Managed Care Systems
1000 N. E. 10th Street
Oklahoma City, OK 73117-1299
Tel. (405) 271-6868 Fax. (405) 271-7360

CWMP COMPLAINT FORM

Name: _____

Mailing Address: _____
Street City State Zip Code

Home Telephone: ( ) _____ Work Telephone: ( ) _____

CWMP Name: _____

Primary Care Physician (PCP) Name: _____

Specialists Physician Name: _____

Member ID Number or Social Security Number: _____

Is this complaint on behalf of someone else? _____ Yes _____ No

If "Yes", please provide the name of that person: _____

1. What is your complaint? Please include copies of any bills, documents or correspondence that you believe will assist us in reviewing this complaint. _____

_____

_____

_____

_____

_____

2. What do you think would be the proper solution to this complaint? _____

_____

_____

_____

Signature: _____ Date: _____

RETURN THIS FORM TO MANAGED CARE SYSTEMS AT THE ABOVE ADDRESS