# Humboldt IPA Member Appeal & Complaint Form

This form is for your use in making suggestions, filing a formal complaint, or appeal regarding any aspect of the care or service provided to you. We will respond directly to you within 30 days about your complaint or appeal or we will forward it to your health plan for resolution.

Appeal System Number (For Humboldt IPA Use Only) | Health Plan and Option, if any

**Please print or type the following information**:

Member Name (Last, first, middle initial | System Tracking Number (claim/auth)

Address | Home Phone number

City, State, Zip | Work Phone number

Name of Employer or Group | Subscriber ID #

Date of Birth | Male/Female

If you are filing a complaint for another person, please provide the following information:
Appeal Requested By: _____ Telephone # _____

Relationship to Member: _____ Fax Number #_____

Address: _____

City: _____ State: _____ Zip: _____

Please state the nature of the complaint, giving dates, times, persons, places, etc. involved and attach copies of any additional information that may be relevant to your complaint or appeal.

Date of Service:_____ Circle one: Authorization Appeal Claim Appeal Complaint

Please attach copies of anything that may help us understand your grievance.
Please sign and mail to: The Humboldt IPA, Medical Management Department, 2315 Dean Street, Eureka CA 95501 or fax to: (707) 442-2047.
Blue Cross California Care members may choose to mail authorization appeals to:
Blue Cross of California/ Complaints and Appeals: P.O. Box 4310, Woodland Hills, CA 91365

Date_____ Signature_____

Date_____ Signature of Representative_____