Humboldt Independent Practice Association **Grievance, Complaint and Appeal 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/Grievance/Complaint ID #: _____
(For IPA Use ONLY)

Health Plan and Option: _____

Please print or type the following information:

Member Name:_____
Last, First, Middle Initial

Address: _____
Street City Zip

Home Phone #:	Date of Birth: Male Female
Work Phone #:	Name of Employer or Group:
Cell/Mobile #:	
Best time to contact you:	Subscriber ID#:

If you are filing a complaint for another person, please provide the following information:
Appeal Requested by: _____
Relationship to Member: _____
Address: _____
Street City Zip
Phone#: _____ Fax#: _____

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.

Circle one: Authorization Appeal Claim Appeal Complaint/Grievance
Authorization or Claim Tracking Number: _____

Date of Service:

Please attach copies of anything that may help us understand your grievance.
Please sign and mail to: The Independent Practice Association, 2662 Harris St., Eureka, CA 95503 or fax to: (707) 442-2047.

Anthem Blue Cross and Blue Shield members may choose to contact their health plan directly:

Anthem Blue Cross ATTN: Grievance and Appeals Department P.O. Box 4310 Woodland Hills, CA 91365-4310 Telephone: 1-800-365-0609 TTD/TTY 1-866-333-4823 Fax: 1-818-234-1089 Internet: www.anthem.com/ca	Blue Shield of California ATTN: Member Appeals and Grievances P O Box 629007 El Dorado Hills, CA 95762-9007 Telephone: 1-800-424-6521 TTD/TTY: 1-800-241-18263 Fax: 1-916-350-7585 Internet: www.blueshieldca.com

_____ _____
Member Signature Date

_____ _____
Signature of Representative Date