OKLAHOMA HEALTH CARE AUTHORITY
PROVIDER/PHYSICIAN APPEAL FORM

In order to process your grievance request, all of the requested information must be supplied. Failure to provide all of the information may result in dismissal of your appeal.

Provider Information:

Company Name (if any):_____ Provider ID#: _____

Individual Name (if any):_____ Federal Tax ID# _____

Mailing Address: _____
NUMBER STREET

_____
CITY STATE ZIP CODE

Phone Number: (___) _____

Date of Adverse Action: _____

Authorized Representative Information (if any):

Name: _____

Mailing Address: _____
NUMBER STREET

_____
CITY STATE ZIP CODE

Phone Number: (___) _____

Provider or Legal Representative Signature: _____

Summary of Case:

Please attach a statement identifying the specific agency action or decision from which you are appealing, together with the legal and factual bases for your appeal. You may also attach copies of any documents you would like to be considered.

Please return the completed form and attachments to:

Docket Clerk, OHCA Office of Hearings and Appeals
P.O. Drawer 18497
Oklahoma City, OK 73154-0497
405.530.3444 (fax)
405.522.7217 (docket clerk)
Email: docketclerk@okhca.org