Member Appeal Form

If you have a complaint or grievance, please complete and submit this form to the Oklahoma Health Care Authority to initiate the Appeals Process. The completed form must be received by OHCA **within thirty (30) days of the triggering event** (the date on which the event you are appealing occurred).

Failure to complete and return this form within 30 days can result in a dismissal or denial of your appeal.

Please provide all requested information, including a complete explanation of the problem/issue. Include the name (s) of any OHCA personnel with whom you have dealt and the dates on which specific events occurred. Use additional paper if necessary. Attach copies of any supporting documentation you would like to be considered.

I. Member Information

Member Name: _____ Member ID: _____

Member's Mailing Address: _____

City_____ State _____ Zip Code _____ Phone Number _____

Email Address _____

Date of Triggering Event: _____

Member's Guardian (if applicable): _____ Guardian Phone: _____

II. Authorized Representative Information (if any)

I, _____, authorize _____ to serve as my representative in connection with this appeal. I authorize my representative to present evidence, to obtain information about my appeal, and to receive notices in connection with my appeal. I understand that my personal health information (PHI) may be disclosed to my Representative. Therefore, I have signed the attached Authorization to permit the disclosure of this information. My Representative agrees that he/she will be available to represent me on the date and time of the appeal hearing set by the Oklahoma Health Care Authority. I do not have a legally appointed Guardian, or my legally appointed Guardian hereby consents to this authorization.

_____ _____

Member Signature *Date* *Authorized Representative* *Date*

Authorized Representative Name: _____

Mailing Address: _____

Phone Number: _____ Email Address: _____

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Please tell us about your request in the space below. Be as specific as possible and whenever possible, give the date(s) on which the event occurred. *[If you need more space, use another sheet of paper.]*

_____

_____

_____

_____

_____

Have you told the individual or organization about the issue? If so, what happened?

_____

_____

_____

_____

_____

What would you like the Oklahoma Health Care Authority to do about this issue?

_____

_____

_____

_____

_____

_____ _____

Member Signature **Date**

_____

Please send this form to:

Oklahoma Health Care Authority
Grievance Docket Clerk
P.O. Drawer 18497
Oklahoma City, OK 73154-0497

Fax Number: 405-530-3444
Phone Number: 405-522-7217
Email: docketclerk@okhca.org