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* required fields

COMPLAINT FORM

We take your concerns seriously. To help us review your request, please provide more information about your experience by completing this form and sending it, along with any relevant attachments, to the address below:

ATTN: Appeals & Grievances
P.O. Box 671, Southborough, MA 01772
Fax: 866-326-1073

Note: If you have any questions about your complaint, please call Member Services **800-680-4568**.

Be sure to accurately complete all sections of this form. All fields marked with an asterisk (*) must be filled out completely. Attach all supporting documentation to your completed form, if applicable.

Member Information*	
Member Name (First Name, Middle Initial & Last Name)*	
Member ID Number*	Member Date of Birth (MM/DD/YYYY)*
Member Address*	
City, State, Zip*	Phone Number*

Authorized Representative Information	
If you are filing a complaint on behalf of a member, please fill out all the information below.	
Authorized Representative (First Name, Middle Initial & Last Name)	
Authorized Representative Address	
City, State, Zip	Phone Number

Provider Information	
If you are a provider filing a complaint, please fill out all the information below.	
Provider Name (First Name, Middle Initial & Last Name)	
Provider Address	City, State, Zip
Phone Number	Provider ID Number

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* required fields

Brief Description*

Briefly describe the incident or your concerns. Please include dates and times, persons involved, and a description of what happened. Please also include attachments if appropriate.*

Disclaimer & Attestation*

By signing this form, the information submitted is accurate and true to the best of my knowledge. I understand that additional information may be needed upon review.

Signature of Person Filling Out the Form*	Date (MM/DD/YYYY)*