



## CERTIFIED WORKPLACE MEDICAL PLAN GRIEVANCE FORM

**Before you complete this form, have you contacted CompCHOICE by phone or fax, and discussed your complaint with the assigned case manager or other Certified Workplace Medical Plan (CWMP) representative? Some issues may be addressed without the need for a formal Grievance process. Medical care issues should be filed as a dispute.**

Under the Oklahoma State Department of Health CWMP Rules, this form is to be used by any Employee, Employer/Insurer/Insured or Provider who has a complaint that is **not related to medical care under the plan**. Medical care issues should be filed as a dispute and will be attempted to be resolved within ten (10) days of receipt. Complete all the requested information such as dates, names, and the specific resolution which you feel would remedy the situation. All pertinent/available records will be reviewed. A written acknowledgement will be issued within seven (7) days, and a final written resolution offered within ninety (90) days of receipt unless one letter combines acknowledgement and resolution.

**Person filing the dispute, checkmark one of these choices:**

Employee     Employer     Insurance Company/Group Self Insurance Association     Provider

**Please Print or Type.**

### EMPLOYEE INFORMATION

Last Name : \_\_\_\_\_ First Name : \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Daytime Phone Number (with area code): (\_\_\_\_) \_\_\_\_\_ SSN#: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### PROVIDER INFORMATION

Name : \_\_\_\_\_ Phone Number : (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### EMPLOYER INFORMATION

Name : \_\_\_\_\_ Phone Number : (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### INSURANCE CARRIER INFORMATION

Name : \_\_\_\_\_ Phone Number : (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

- Briefly describe the situation that prompted this grievance about an issue **other than medical care**. Provide dates, names, and any other pertinent facts that relate to the dispute. Attach additional sheets or copies, as necessary. State what actions you feel that CompCHOICE could take to remedy your dispute:

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Signature

Date