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:

_____

_____

_____

_____ _____

Signature **Date**

CompCHOICE ● P. O. Box 238800, Oklahoma City, OK 73123 ● (405) 848-3595 ● Fax (405) 841-9364