HARMONY HEALTH PLAN

Provider Complaint Form

❑ Illinois Medicaid

Request Date: _____

Provider Information

Name: _____

Address: _____

City: _____

Telephone: _____

Fax: _____

Contact Person: _____

Patient Information

❑ **Multiple Members**
(List on separate sheet)

Name: _____

ID Number: _____

Date of Birth: _____

Information on Service Provided

Date(s) of Service: _____

Place of Service: _____

√ Complaint Reason

__ Harmony Administration
__ Member Behavior
__ Health Care Delivery
__ Provider Reimbursement
__ Contracting

Explanation of Issue(s)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Fill out the form completely and keep a copy for your records. Send this form with all documentation to support the complaint to Harmony Health Plan, Attn: *Grievance Department at* P.O. Box 31384 Tampa, FL 33631-3384. Your request will be processed once all necessary documentation is received and you will be notified of the outcome.

*Failure to submit supporting documentation may delay our response to your complaint.