MEMBER COMPLAINT FORM

If you wish to file a formal complaint regarding the care or service which you have received from CDPHP® or any of our participating providers, please complete this form and return it to our Complaint, Grievance and Appeals Department. The information you provide will assist us in investigating your concerns.

Member Information

Name of Member Involved: _____

Member ID: _____

Address: _____

City, State, Zip _____

Telephone Number: _____

Name of Person Filing Complaint (if different):_____

Provider Information

Is your complaint regarding a particular provider or CDPHP service? Please check the appropriate box.

☐ Provider (MD, Pharmacy, Laboratory, Vendor) ☐ CDPHP

Provider Name: _____

Date of Service:_____

Location: _____

_____

Primary Complaint: *Please complete the following*.

Briefly describe the reason for seeking medical care or service from CDPHP:_____

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Please describe the problem which you would like CDPHP to address: _____

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Please state your concerns regarding this incident:_____

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Signature: _____ Today's Date:_____

Based on the information you have provided, CDPHP will make every effort to resolve your complaint in a satisfactory and timely manner.

Return to: CDPHP Appeals Department
6 Wellness Way
Latham, NY 12110

Capital District Physicians' Health Plan, Inc. (CDPHP); CDPHP Universal Benefits, Inc.® (CDPHP UBI); Capital District Physicians' Healthcare Network, Inc. (CDPHN).