PO Box 1508
Riverside, CA 92502-1508

Email: EPO@RIVCO.ORG

Fax: 951-955-0055

The Exclusive Provider Health
Plan of the County of Riverside

For questions please call our Member Service Department at 800-962-1133, option 1

MEMBER COMPLAINT/CONCERN FORM

Please complete the following form and mail, email, or fax it to the attention of Member Services at the address or phone number above.

Date of Incident: _____

Member's Name_____ **Member ID#**_____

Complainant's Name_____**Relationship**_____

Address_____ **Daytime Phone**_____

_____ **Alt. Phone**_____

Name of Facility/Department, Doctor (PCP), Staff Member, or Person(s) involved _____

_____

Complaint/Concern– Please provide us with as much detail as possible. This will assist us in the investigation. Use additional paper if needed and attach any other document(s) regarding this incident. After completion of this form, please return to the address, or email address, or fax number provided above. You will receive an acknowledgement letter within 5 business days of receipt of the completed form. A notice will be sent to you within 20 days of any final action taken by Exclusive Care, when appropriate. Thank you in advance for taking the time to notify us with your complaint/concern.

_____

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_____

Member's signature: _____ **Date:** _____

Signature of Parent or Legal Guardian: _____**Date**_____

ALL INFORMATION IS KEPT CONFIDENTIAL

For Exclusive Care Only:

Date Received_____ **Date Acknowledgement Sent** _____

Final Response Sent_____

P.O. Box 1508 • Riverside • CA • 92502 (800) 962-1133
ATTN: Member Services

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