CCHP PROVIDER COMPLAINT FORM

Submit for the following: Member discharge from panel and interactions with CCHP staff.
Please include any supporting documentation.

Provider Name: ______________________________ Date: ______________________________

Provider Phone: ______________________________ Fax #: ______________________________

Issue: ☐ Member ☐ CCHP Employee ☐ Other

Member/Employee Name: ______________________________

ID#: ______________________________ Birthdate: ______________________________

Provider Issue/Complaint (Please include as much detail as possible including language used, frequency of occurrence, reaction of staff and/or patients)

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Action You Are Requesting

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Treatment

Is the member receiving treatment that requires attention in the next 30 days?

☐ Yes ☐ No

If yes, what type of service:

____
____

Medications

Does the member have a prescription due to be renewed in the next 30 days?

☐ Yes ☐ No

If yes, please check which:

☐ Non-opioid ☐ Opioid

Staff Signature: ______________________________ Date ______________ Forwarded to: ______________

Print Name ______________________________

Please encrypt and email the completed form and supporting documents to NetworkManagementTeam@cchealth.org or fax to (925) 608-9411.