

**MEMBER COMPLAINT/GRIEVANCE FORM**

**Member Information:**

Name of Member involved in Complaint/Grievance: \_\_\_\_\_ CIN #: \_\_\_\_\_

Head of Household/Guardian: \_\_\_\_\_ File #: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**Explanation of Incident/Complaint:**

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**Reason(s) for Complaint:**

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**How would you like your complaint resolved/determined:**

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Signature of Complainant or Designee: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return this form to:** Suffolk Health Plan  
4944 Parkway Plaza Blvd, Suite 110  
Charlotte, NC 28217  
Attn: Member Services Center or fax to 800-338-4195

**For Official Use Only — Please do not write below this line**

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Receipt of the Complaint (Date): \_\_\_\_\_ Received by: \_\_\_\_\_

Clinical Complaint:    No    Yes    If yes, refer to: \_\_\_\_\_ Date referred: \_\_\_\_\_

Reviewed and approved by (Signature): \_\_\_\_\_ Date: \_\_\_\_\_