OKLAHOMA
State Department
of Health

OKLAHOMA STATE DEPARTMENT OF HEALTH PROTECTIVE HEALTH SERVICES
Health Resources Development Service Managed Care Systems
123 Robert S. Kerr, 12 floor Rm. 1254 Oklahoma
City, OK 73102
Tel. (405) 426-8175 Fax. (405) 900-7571

CWMP COMPLAINT FORM

Name: _____

Mailing Address: _____
Street City State Zip Code

Home Telephone: ( ) _____ Work Telephone: ( ) _____

CWMP Name: _____

Primary Care Physician (PCP) Name: _____

Specialists Physician Name: _____

Member ID Number or Social Security Number: _____

Is this complaint on behalf of someone else? _____ Yes _____ No

If "Yes", please provide the name of that person: _____

1. What is your complaint? Please include copies of any bills, documents or correspondence that you believe will assist us in reviewing this complaint. _____

_____

_____

_____

_____

_____

2. What do you think would be the proper solution to this complaint? _____

_____

_____

_____

Signature: _____ Date: _____

RETURN THIS FORM TO MANAGED CARE SYSTEMS AT THE ABOVE ADDRESS