Network Complaint / Appeal Form

### Injured Worker
- **Injured worker name**
- **Address**
- **Insurance carrier & employer**
- **Claim number**
- **Date of injury**
- **Current treating doctor**

### Complainant
- **Complainant name**
- **Complainant address**
- **Phone/fax numbers**

#### Please select a complaint category
- Quality of care or services
- Accessibility and availability of services or providers
- Utilization review and retrospective review
- Complaint procedures
- Healthcare provider contracts
- Bill payment
- Fee disputes
- Denial of treating doctor change or specialist referral
- Miscellaneous

#### Please explain the circumstances of the complaint. Please provide details.
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________________________________________________________________________
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________________________________________________________________________
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Please attach any additional documentation and/or medical records to support this complaint.

**Complainant Signature**

**Date**

**Complaints should be submitted to the CompKey Plus Network Coordinator**

at the above address, fax, phone or email.

The Network shall acknowledge receipt of the complaint within seven calendar days of receipt. The network shall investigate the circumstances of each complaint and appeal received and shall issue a resolution letter not later than the 30th calendar day after the network receives the written complaint.