

**OKLAHOMA HEALTH CARE AUTHORITY
PROVIDER/PHYSICIAN GRIEVANCE FORM**

In order to process your grievance request, all of the requested information must be supplied. Failure to provide all of the information will result in an automatic denial of your appeal.

Provider Information:

Company Name (if any): _____ Provider ID#: _____

Individual Name (if any): _____ Federal Tax ID# _____

Mailing Address: _____

NUMBER

STREET

CITY

STATE

ZIP CODE

Phone Number: () _____

Date of Adverse Action: _____

Authorized Representative Information (If any):

Name: _____

Mailing Address: _____

NUMBER

STREET

CITY

STATE

ZIP CODE

Phone Number: () _____

Please give a complete narrative explanation of the problem you have encountered. Include the names of OHCA personnel you have dealt with, and the date(s) that specific event(s) occurred. Use additional paper if necessary. Attach copies of any documents you would like to be considered. If your appeal involves a recipient denial, please include the pertinent case number. [If you need more space, use another sheet of paper]

PLEASE SEND THIS FORM TO:

Oklahoma Health Care Authority
Grievance Docket Clerk
Legal Division
P.O. Drawer 18497
Oklahoma City, OK 73154-0497
405.530.3444 (fax)
405.522.7217 (office)