MEMBER COMPLAINT FORM

Please mail to: MSI PO Box 355 Santa Ana, CA 92702 ATTN: Appeals & Grievances



For questions, please call MSI Appeals & Grievances 714-834-3589

MEMBER INFORMATION						
First Name	Middle Name		Last Name		Member ID or SSN:	
Telephone Number:	Person Making Complaint (if different from Member)				Date:	
Street Address	Apt. #		City		Zip Code	
TYPE OF COMPLAINT Please Check:						
☐ Problem with Doctor or ☐ Problem Getting a Refe ☐ Received Bill from Pro ☐ Other:	rral vider (Please attach o		ce/Facility Problem			
DESCRIPTION OF CO	MPLAINT					
Person Completing this Form, State Relationship to Member:				Use s	Use second sheet if required	
	arent \square on/Daughter \square	Advocate Authorize	d Representative			
<u>x</u> Print	Name			<u>x</u> Tit	le (If Applicable)	
<u>x</u>			<u></u>			
Signature of Party Completing this Form				Date		