Member Complaint/ Grievance Form

National

When you're not happy, neither are we. We'd love the opportunity to hear from you, and the chance to make it right. If you'd rather call or complete our **GRIEVANCE FORM**, call us at **800.877.7195** or visit **vsp.com**.

YOUR INFORMATION

Primary Member First/Last Name____________________

Last four of SSN or Member ID#____________________

Date of Birth____________________

Phone Number____________________ Email Address____________________

Address ____________________

City____________________ State__________ ZIP code__________

Client Name, employer, or HMO____________________

Patient First/Last Name____________________

Your relationship to the patient: ☐ Self ☐ Spouse ☐ Child ☐ Other____________________

Are you an authorized representative for this patient? ☐ Yes ☐ No

DOCTOR DETAILS ☐ This grievance is not related to a doctor's visit.

Doctor Name____________________ Date of Service__________

Doctor Phone____________________

What's on your mind?____________________

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How can we help?____________________

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Is your grievance related to a violation of Privacy or Security of Health Information (HIPPA)? ☐ Yes ☐ No

Send this to **VSP®, Attn: Complaint & Grievance Unit, PO Box 997100, Sacramento, CA 95899-7100**.
Once we receive this form, you'll receive an acknowledgement letter within five calendar days and a resolution letter within 30 calendar days.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

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