



Member Complaint Form

This form has been supplied so that you may describe your complaint and have it reviewed and responded to by the Healthfirst Appeals and Grievances Department. Please give dates, times, places and persons involved. If you need help completing this form please call the Healthfirst Member Services Department toll free at **1-866-GO-FOR-HF** (1-866-463-6743). You have the right to make a complaint directly with an area office of the NY State Department of Health regarding medical care. Please refer to the Healthfirst Member Handbook for a listing of area office(s) address(s) and telephone number(s).

SECTION 1: MEMBER INFORMATION

MEMBER NAME: _____ MEMBER ID NUMBER: _____
First Name Last Name

MEMBER ADDRESS _____
Street Apt. # City State Zip

TELEPHONE NUMBER* (_____) _____
Area Code

SECTION 2: COMPLAINT INFORMATION:

NAME OF PERSON FILING COMPLAINT IF NOT MEMBER** _____ RELATIONSHIP TO MEMBER _____
First Name Last Name

COMPLAINANT ADDRESS _____
Street Apt.# City State Zip

TELEPHONE NUMBER* (_____) _____
Area Code

* If you do not have a telephone, please list the phone number of a family member, neighbor or other person who can locate you.
** If other than head of household, please provide documentation of legal guardianship or member's written consent to represent.

SECTION 3: PROVIDER INFORMATION:

PROVIDER NAME _____
First Name Last Name

ADDRESS _____
Street Apt.# City State Zip

TELEPHONE NUMBER* (_____) _____ Date of Visit: _____
Area Code

Description of Complaint: _____

Signature of Member or Complaint Date

Signature of Representative Providing Assistance Date

Please return this completed form to:
Healthfirst
P.O. Box 5166
New York, NY 10274-5166
Telephone: 1-866-GO-FOR-HF
(1-866-463-6743)
(for English, Español, Русский, 中文)