Grievance (Complaint) Form

Section A: Member Information

Last Name	First		Initial
Date of Birth (MM/DD/YYYY)	Date of Incident		
Address	City	State	Zip
Evening Phone	Daytime Phone	Contact Hours (Please specify when you prefer to be called)	
Please Check One: ☐ Verda Noble Care (HMO) ☐ Verda Noble Care (HMO C-SNP)		Member ID	

Section B: Please give a simple reason for your complaint: (or add additional pages if needed.)

Section C:

I certify that the statements made in this complaint are true and correct to the best of my information and belief.

_____ _____

Signature **Date**

If the complaint is filed by a personal representative on behalf of the individual, complete the following and check the appropriate box.

Print Name of Personal Representative: _____

_____ _____

Signature **Date**

☐ Legal Guardian ☐ Power of Attorney ☐ Executor/Conservator ☐Other _____

Please return this form to:

Verda Health Plan of Texas
Attn: Grievance & Appeals
7755 Center Ave, Suite 1200
Huntington Beach, CA 92647

Fax: 714-845-9839
Email: GandA@VerdaHealthcare.com