COMPLAINT FORM

PARTICIPANT INFORMATION

Participant Name (Last) (First)	Birth Date: Mo./ Day/ Yr.	Member ID # (if applicable)
Address (Street) (City) (State)		(ZIP Code)
Telephone (Home)	(Cell)	(Alternate)
Name of person completing this form, if different from participant name	(Daytime Telephone)	

Where did the problem occur? (Name of Hospital, Medical Home, Clinic or Pharmacy)	Date of Incident: Mo./ Day/ Yr.

Please describe what happened as specifically as possible: Include the order in which things happened and how you were affected. **For additional space attach a separate piece of paper.**

What action or result are you asking for?

Signature of participant or representative ______________________ Date: ______________

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You have the option of calling My Health LA Member Services to file a complaint at 1-844-744-6452 or you may return this form to My Health LA Complaint Unit by doing one of the following:

- Fax to MHLA/DHS Grievance & Appeals Unit at (626) 299-3390
- Mail to MHLA/DHS Grievance & Appeals Unit, 1000 S. Fremont Avenue, Bldg. A-11, Ground Floor, Suite 11010, Alhambra, CA 91803-8859

Upon receipt of your complaint, My Health LA Complaint Unit will investigate your complaint and a Complaint Coordinator will contact you for additional information. You will receive a written response within 60 days.

If you have questions or require assistance, please contact Member Services at 1-844-744-6452.

INTERNAL USE ONLY
OUTCOME/RESOLUTION:
1. Medical Home 2. Participant ID/MRUN 3. Complaint Code 4. Complaint received : In Person ☐ By Phone ☐ By Mail ☐ By Fax ☐
Complaint Received By: Time: Date: