



# MEDCOM CARE MANAGEMENT, INC. COMPLAINT FORM

This form is for your use in making suggestions, or for filing a formal complaint regarding any aspect of the service provided to you. If you have any questions, please feel free to call our Medical Management Department at 1-800-643-4416.

Insured Name (Last, first, middle initial) Male/Female Date of Birth

Address Home Phone Number

City, State, Zip Work Phone Number

Name of Employer or Group (if applicable) PID #

Please state the nature of the complaint, giving dates, times, persons, places, etc. involved. Please attach copies of any additional information that applies to your complaint.

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Please sign and MAIL to MedCom Care Management, Inc. at P.O. Box 1751, Covington, LA 70434.

Date Signature

Date Signature of Representative