Return this form by Mail or Fax:
ODS Appeal Unit
ODS Health Plan, Inc.
601 SW Second Avenue
Portland OR 97204
Fax (503) 412-4003

ODS COMPLAINT AND APPEAL FORM

Name of Person Filing Complaint/Appeal			☎ Telephone#
Address	City	State	Zip
Member Name	Patient Name	Member's ID#	Group#
Name of Provider Involved	Address		☎ Telephone#
Name of Provider Involved	Address		☎ Telephone#
Date(s) of Service			

Please type or write your complaint or appeal in the space below and on the back of this page. Attach additional pages if needed. You may include any document such as explanation of benefits (EOBs), correspondence, or invoices which will help us investigate your complaint or appeal. Please sign and date this form.

Signature:_____ Date:_____

Upon receipt of your complaint or appeal, ODS will mail you an acknowledgement letter.

_____
Name of person filing Complaint/Appeal