Return this form by Mail or Fax:
ODS Grievance Resolution Unit
ODS Companies
601 SW Second Avenue
Portland OR 97204
Fax (503) 243-5105
Upon receipt of your grievance or appeal, ODS will mail you an acknowledgement letter.

ODS GRIEVANCE AND APPEAL FORM

Name of Person Filing Complaint ☎ Telephone#

Address City State Zip

Subscriber Name Patient Name Subscriber ID# Group#

Name of Provider Involved Address ☎ Telephone#

Name of Provider Involved Address ☎ Telephone#

Date(s) of Service

Please type or write your grievance or appeal in the space below and on page 2. 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 grievance or appeal. Please sign and date this form.

Signature:_____ Date:_____

_____
Name of person filing complaint