Texas Star Network® FORMAL COMPLAINT FORM

Date Received: _____

INITIATOR OF COMPLAINT

Name:
Address:
City: State: Zip:
Telephone #: ( )

Complaint Initiated by: Provider ☐ Employee ☐ Employer ☐ Carrier ☐

Complaint Involves: Service ☐ Medical Care ☐ Other ☐

Employee Name:	Employer Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Telephone #: ( )	Telephone #: ( )
SSN:	

Group Name:	Insurer:
Provider Name:	Contact:
Address:	Address:
City: State: Zip:	City: State: Zip:
Telephone #: ( )	Telephone #: ( )

Please describe your compliant in detail below. Include dates, names and the specific resolutions that you feel might remedy the situation. You have up to 90 days from the date of the dissatisfaction to file a formal complaint. ***PLEASE ATTACH COPIES OF APPLICABLE MEDICAL RECORDS TO THIS FORM.***

Date of Injury: _____ Date of Dissatisfaction: _____

Please describe**: _____

_____

**If you need more space, please use additional sheets.

Signature **Date**

Mail this form to the address noted below, or fax to (630) 737-2077. For questions, please call (800) 262-6122, option 4.

Texas Star Network®
Attention: Grievance Coordinator
3200 Highland Avenue
Downers Grove, IL 60515