# Grievance (Complaint) Form

**Section A: Member Information**

<table>
<tr><td>Last Name:</td><td colspan="2">First Name:</td><td colspan="2">Initial:</td></tr>
<tr><td colspan="2">Date of Birth (MM/DD/YYYY):</td><td colspan="3">Date of Incident (MM/DD/YYYY):</td></tr>
<tr><td>Address:</td><td colspan="2">City:</td><td>State:</td><td>Zip:</td></tr>
<tr><td>Evening Phone:</td><td colspan="2">Daytime Phone:</td><td colspan="2">Contact Hours (please specify when you prefer to be called):</td></tr>
<tr><td colspan="3">Please Check One: ☐ Verda Noble Care (HMO)<br>☐ Verda Noble Care (HMO C-SNP)</td><td colspan="2">Member ID:</td></tr>
</table>

**Section B: Please give a simple reason for your complaint (attach additional pages if needed):**

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**Section C:**

**I certify that the statements made in this complaint are true and correct to the best of my information and belief.**

**Signature:** ____________________________________________ **Date:** _______________

**If the complaint is filed by a personal representative on behalf of the individual, complete the following and check the appropriate box.**

**Name of Personal Representative:** __________________________________________________

**Signature:** ____________________________________________ **Date:** _______________

☐ Legal Guardian ☐ Power of Attorney ☐ Executor/Conservator ☐ Other: ______________________

Please return this form to:

Verda Health Plan
Attn: Grievance & Appeals
7755 Center Ave, Suite 1200
Huntington Beach, CA 92647

Fax: 714-845-9839

Email: GandA@VerdaHealthcare.com