OHARA Complaint/Grievance Form

PLEASE COMPLETE AND SEND TO:
OHARA Managed Care
Attention: Lynette Huber, Director of Nursing
PO Box 89527 Sioux Falls, South Dakota, 57109
Phone: 605-361-1071 or 1-800-363-4272 Fax: 605-361-1106

Information from person filing the complaint:

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip Code

Telephone(day time): _____Fax Number: _____

Social Security Number (Of insured or injured worker filing complaint): _____

Date of Injury: _____ Specialty (If Provider filing complaint): _____

Insurance Carrier: _____ Claim Number: _____

Employer: _____ Telephone Number: _____

Employer Address: _____
Street City State Zip Code

Please describe in detail the nature of your complaint. (Please type or print clearly):

_____
_____
_____
_____

It is the goal of the case management plan to resolve this issue within 30 days of receipt of this form. At that time, should resolution not be achieved, or there continues to be dissatisfaction of the results, an appeal may be made to the South Dakota Department of Labor.

Please attach any documentation/documents that you want considered in the investigation of your complaint/problem. Have you attached documents to this complaint? ____ yes ____ no

_____
(Print or Type) Name of Person Filing Complaint

_____ _____
SIGNATURE DATE

Received at OHARA: _____