PROVIDER GRIEVANCE FORM

As the provider, you can fill this out for a member. Please indicate the program the member is enrolled in:

LINE OF BUSINESS INVOLVED *(check all that apply)*

☐ CHP+ offered by Colorado Access ☐ CHP+ State Managed Care Network

☐ Regional Accountable Entity/regional organization (RAE)

MEMBER INFORMATION

Member name:

Member ID number:

Name of member's guardian (if applicable):

Phone:

DESCRIPTION OF PROBLEM *(if needed, write on the back of this form or add another page)*

Date(s) of incident:

Person(s) or provider(s) involved:

Please explain:

Mail to:
Grievance and Appeals Department
Colorado Access
PO Box 17950
Denver, CO 80217-0580

To speak with someone directly, call our grievance department at 877-276-5184.
TTY/TDD users call 888-803-4494.