GRIEVANCE FORM

USA MANAGED CARE ORGANIZATION
1250 S. Capital of Texas Hwy, Bldg 3-500
Austin, TX 78746
ATTN: Medical Review Committee

CLAIMANT'S NAME: _____

CLAIMANT'S ADDRESS _____

_____

CLAIMANT'S PHONE #: _____

EMPLOYER NAME: _____

PROVIDER/FACILITY NAME: _____

*** Note: USA Managed Care Organization cannot thoroughly investigate this complaint/grievance without written consent to obtain copies of your medical records or other related documents. Records are kept confidential and used solely for the purpose of grievance resolution.

☐ Yes, I hereby authorize USA Managed Care Organization permission to obtain and review all medical and/or other related records. You may disclose my name and nature of this concern in order to obtain additional information. I agree to a photostat and/or facsimile of this release being accepted, if necessary.

☐ No, I do not authorize disclosure of my name or nature of this concern in order to obtain additional information.

_____ _____
Claimant Signature Date

FOR INTERNAL USE ONLY	
DATE RECEIVED	
CONCERN NUMBER ASSIGNED	

Please provide a narrative of the nature of your grievance. Include all pertinent information including; contact names, dates of service, correspondence and conversations. Please attach copies of all documents related to the grievance, if applicable. You will receive written confirmation from USA upon our receipt of the Grievance Form. Your Grievance will be thoroughly researched and all information will be submitted to USA's Medical Review Committee at the next regularly scheduled meeting for consideration and action.