



GRIEVANCE FORM

USA MANAGED CARE ORGANIZATION
916 South Capital of Texas Hwy.
Austin, TX 78746
ATTN: Linda Saidla – Provider Relations

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	

