COVENTRY WORKERS' COMP NETWORK
TEXAS - FORMAL COMPLAINT FORM

Date Coventry Workers' Comp Network Received: _____

INITIATOR OF COMPLAINT		
Name:		
Address:		
City:	State:	Zip:
Telephone #: ( )		

The initiator of the complaint is: ___ Provider ___ Carrier ___ Employer ___ Employee

___ Authorized representative designated to act on behalf of the employee

Employee Name:			Employer Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Telephone #: ( )			Telephone #: ( )		
SSN:					

Group Name:			Insurer:		
Provider Name:			Contact:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Telephone #: ( )			Telephone #: ( )		

Please describe your complaint in detail below. Include dates, names, and the specific resolutions, which you feel might remedy the situation. You have up to 90 days from the date of the dissatisfaction to file a formal compliant. **PLEASE ATTACH COPIES OF APPLICABLE MEDICAL RECORDS TO THIS FORM.**

This issue involves: Service _____ Medical Care _____ Other _____

Date of Injury: _____ Date of Dissatisfaction: _____

Please describe:

_____

_____

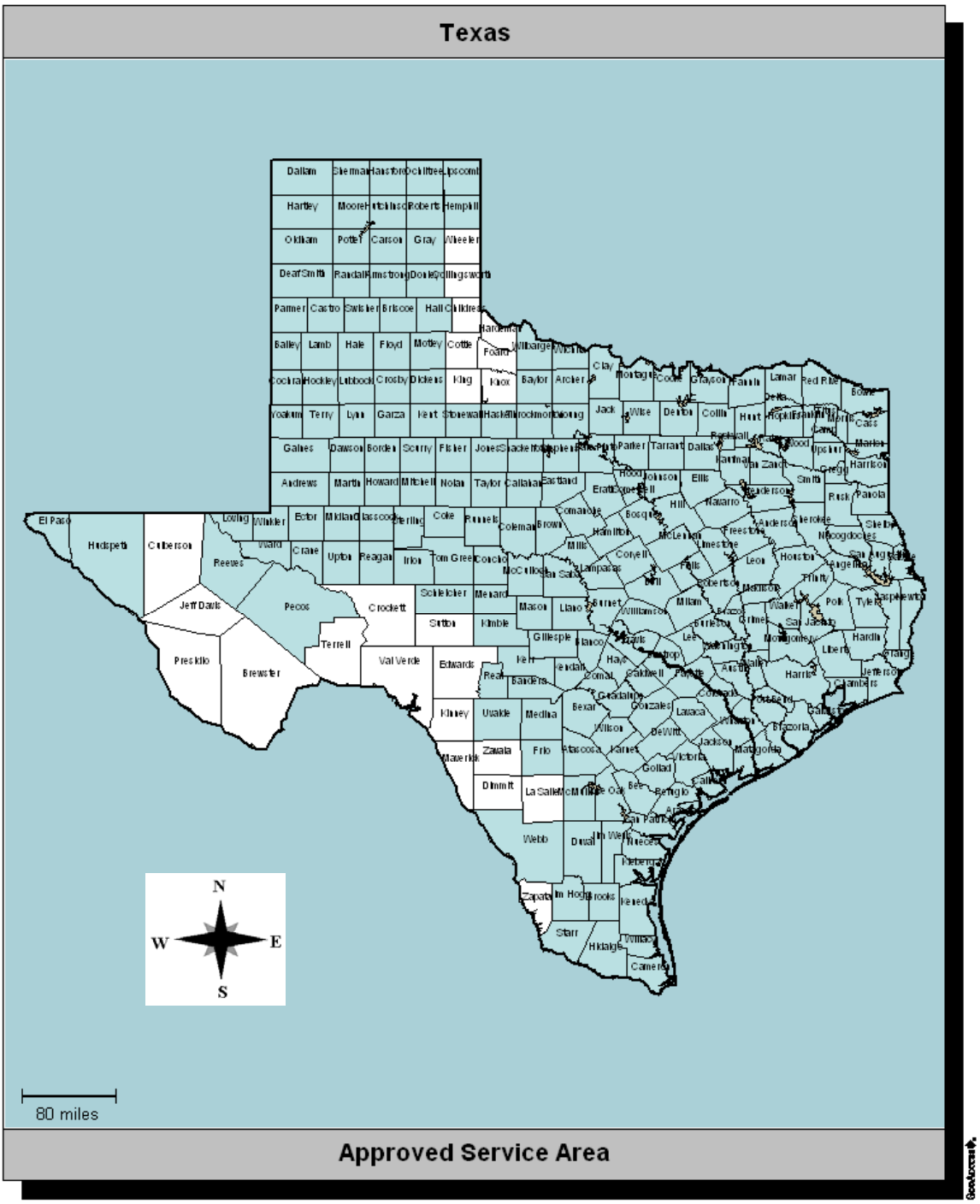
_____

_____

_____If additional space for comment is required, please use additional sheets.

Signature **Date**

Mail this form to the address noted below or fax to: (615)-224-9129.

Coventry Workers' Comp Network
Attention: Grievance Coordinator
720 Cool Springs Boulevard, Suite 300
Franklin, TN 37067
1-800-873-0055

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