



# Complaint/Grievance Form

## TriWest Healthcare Alliance Department of Veterans Affairs (VA) Programs

### Instructions

If you have a Complaint/Grievance, TriWest would like to hear from you.  
After completing this form please mail or fax it to:

**TriWest Healthcare Alliance**  
**Congressional Relations & Customer Grievances**  
**P.O. Box 41970 Phoenix, AZ 85080-1970**

**Fax: (602) 564-2523**

### Person Completing Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Email: \_\_\_\_\_  
Relationship to Veteran: Self: Family/Caregiver: Provider: Other: \_\_\_\_\_

### Veteran Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Member ID: \_\_\_\_\_  
Email Address (if applicable): \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Complaint and/or Grievance Information

Health Care Provider's Name (if applicable): \_\_\_\_\_  
Date(s) of Incident(s): \_\_\_\_\_

**Describe your concern(s):** Please be as specific as possible about your concerns. We will contact you if more information is needed. You may attach additional pages or supporting documentation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for submitting your concern(s). One of our representatives will be in touch with you within seven (7) business days from receipt of your concern.

The Information collected with this form is subject to the Privacy Act of 1974 (5 U.S.C. 552A, as amended) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information shall be considered for official use only and protected accordingly. Any individual responsible for unauthorized disclosure or misuse of this information may be subject to a fine of up to \$50,000 and/or other sanctions as appropriate.