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.