Return this form by Mail or Fax: **ODS Appeal Unit** ODS Health Plan, Inc. 601 SW Second Avenue Portland OR 97204 Fax (503) 412-4003



ODS COMPLAINT AND APPEAL FORM

Name of Person Filing Complaint/Appeal			
Address	City	State	Zip
Member Name	Patient Name	Member's ID#	Group#
Name of Provider Involved	Address		
Name of Provider Involved	Address		
Date(s) of Service			
Please type or write your complain needed. You may include any do help us investigate your complaint of	cument such as explanation of be	enefits (EOBs), correspondence	e, or invoices which wil
Signature:		Date:	

Upon receipt of your complaint or appeal, ODS will mail you an acknowledgement letter.

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Name of person filing Complaint/Appeal		