

CENTRAL VALLEY INDIAN HEALTH, INC.
20 NORTH DE WITT AVENUE
CLOVIS, CA 93612
(559) 299-2578

GRIEVANCE FORM

This form is to be used by patients to file formal grievances at Central Valley Indian Health, Inc.

Patients Name

Clinic or CVIH site where grievance occurred

Date grievance filed

Date grievance occurred

Are you a Medi-Cal Managed Care Patient? _____ Yes _____ No

If so, which plan are you with? _____ Blue Cross _____ Health Net

Please describe the grievance you are submitting. Include as many facts as possible.

Signature of patient filing grievance: _____

(If additional space is needed, attach another sheet or write on the back of this form)