Health Resources Development Service

Oklahoma State Department of Health

Print Form | Submit by Email

Managed Care Systems
1000 NE 1th Street
Oklahoma City, OK 73117-1299
405.271.6868
Fax 405.271.7360

HMO COMPLAINT FORM

Complete and return this form to Managed Care Systems at the above address or submit via Email by clicking the button in the upper right-hand corner of this form.

Name _____

Mailing Address _____ _____ _____ _____
Street City State Zip Code

Phone Number _____ Work Number _____

HMO Name _____

Primary Care Physician (PCP) Name _____

PCP's Medical Group Name _____

Member ID Number or Social Security Number _____

Is this complaint on behalf of someone else? ☐ Yes ☐ No

If "Yes", please provide the name of that person. _____

What is your complaint? Please include copies of any bills, documents or correspondence that you believe will assist us in reviewing this complaint.

What do you think would be the proper solution to this complaint?

Signature _____ Date _____

A Digital ID Signature May Be Used Here _____