THE OHIO STATE UNIVERSITY
HEALTH PLAN

Member Concern Record

Record completion instructions: Provide requested information and fax to: 614-292-2667. You may also email the record after saving a copy to: UtilizationManagement.OSUHealthPlan@osumc.edu or USPS mail the record to:

The Ohio State University Health Plan, Inc.
700 Ackerman Road
Suite 1007
Columbus, OH 43202
Attn: Quality Improvement Manager

Please print the following information:

Member First Name: _____ Last Name:

Patient's First Name (if different than you)**:_____ Last Name:**

Member Identification Number (See insurance card)**:**

Health Care Provider's Full Name: _____

Date(s) of the appointment or services: _____

Please describe below what happened and state any concerns you wish to make known about the incident.
(Additional writing space on back)

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****Receipt of this form will be acknowledged within 5 business days *****

*****To further evaluate your inquiry please be aware that this information may be shared with those providers you name on this form. *****