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)