

Provider Grievance or Complaint Form

County Medical Services Program (CMSP) providers may use this form to file a written grievance or complaint regarding any aspect of our services **not** related to an action, medical procedure, or authorization for service. Providers may submit grievances or complaints orally to Advanced Medical Management, Inc. (AMM) Customer Service at 1-877-589-6807. You may also complete this form, attach any related documents, and mail or fax the completed form and documents to:

CMSP- Advanced Medical Management
Attn: Customer Service - Grievances
5000 Airport Plaza Drive, Suite 150
Long Beach, CA 90815
Fax (562) 766-2006

Provider Name: _____

Provider ID-NPI# _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Information about the Grievance

This information becomes part of your permanent record; write clear and legible.

Date of Incident: _____

Describe what happened. Attach additional pages if necessary.

Signature of Provider

X _____ Date: _____

To file an appeal regarding medical benefits that are denied, reduced, or terminated in whole or in part, you may complete a Provider Appeal form located on AMM's website at <http://cmsp.amm.cc/providers/>.