Member Concern Record

Please provide the following information:

Your name:_____

Patient's name (if different than yours):_____

OSU Health Plan Identification Number:_____

Health care provider's name:_____

Date(s) of the appointment or services:_____

Please describe what happened and state any concerns you wish to make known to OSU Health Plan. (Additional writing space on back)

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Please fax this form to (614) 292-2667 or mail to:

The Ohio State University Health Plan, Inc.
Attn: Quality Improvement Specialist
Suite 440
700 Ackerman Road
Columbus, OH 43202

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