Oklahoma Workplace Medical Plan

Intracorp℠

Grievance Form

EMPLOYEE INFORMATION

SUBMITTED BY ☐ **Employee** ☐ **Provider**

Last Name		First Name	
Address			
City	State	ZIP Code	Phone Number

PROVIDER INFORMATION

Name			
Address			
City	State	ZIP Code	Phone Number

EMPLOYER INFORMATION

Name			
Address			
City	State	ZIP Code	Phone Number

GRIEVANCE INFORMATION

Please describe your grievance in detail, including any action you believe would remedy the situation. Also include the date of the occurrence giving rise to the grievance and any other dates and names that are relevant. Use additional paper if necessary.

Signature **Date**

Intracorp will review this grievance and respond with an initial response to the grievance within 7 days of receipt. A final determination on the grievance shall be made within 90 days after the grievance is filed, if all documents or records necessary to reach a decision have been submitted. If you need assistance with your grievance, you may request assistance from the Oklahoma Commissioner of Health at 1000 Northeast 10th Street, Oklahoma City, OK 73117-1299.

Please submit this form to: <Name and Address of the supervisor in the unit where the business is being done>.