ACHP
By Sendero

Complaint Form

Date: _____

Name of Member: _____

Street Address: _____

City/State/Zip: _____

Re Member:

Member ID:

Information regarding my complaint:

_____

_____

_____

_____

_____

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The Complaint Form must be completed and returned to Access to Care Health Plan by Sendero (ACHP) by faxing it to 512-901-9724 or mailing to:

Access to Care Health Plan by Sendero
Attn: Operations Department
1111 East Cesar Chavez
Austin, TX 78702

If you have any questions or concerns, please call ACHP Customer Service toll-free 1-844-800-4693.

I understand that the signature below allows for the release of medical records to ACHP for use in looking into my complaint. I also understand that if I'm completing this form on behalf of another person, the signature must be that of the parent or legal guardian.

The medical records are being released only for the purpose of reviewing this complaint. Any other use is not allowed.

I understand that I may withdraw this authorization at any time unless action has already been taken based on it. This authorization will expire one year from the date of my signature, or as otherwise specified by date, event, or condition as follows:

Signature of Member: _____Date: _____