[DATE]

[PROVIDER NAME]

[CLINIC NAME]

[STREET ADDRESS]

[CITY, STATE ZIP]

# SUBJECT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GRIEVANCE

Dear Dr. [Provider Name]:

On [DATE], IEHP received your grievance against [MEMBER, IPA, HOSPITAL OR IEHP]. Thank you for bringing this matter to our attention, your concerns are important to us.

IEHP is currently taking the necessary steps to immediately resolve your grievance. You will be contacted if we have any further questions. IEHP’s Director of Provider Relations will resolve your grievance, within thirty (30) calendar days.

If you have any questions or concerns regarding the status of your grievance, please call me at (909) 890-XXXX.

Sincerely,

[Director Name]

Director of Provider Relations, IEHP

cc:

 Manager Name, Manager of Provider Relations, IEHP

 PSR Name, Provider Services Representative, IEHP

 File location (see policy and procedures PRO/GEN 03) ex. F-120.a