CHRISTUS Health Plan

Complaint and Complaint Appeal Request Form

Please complete the form below with information about member's complaint/complaint appeal

Member Name:	
Member ID #:	Date of Birth:
Authorized Representative*:	
Phone Number:	
Address:	
Claim Number:	
Authorization Number(if applicable):	
Date(s) of Service:	
Name of Provider:	

Please explain your complaint or complaint appeal in this section. You can attach extra information to support your complaint or complaint appeal:

Mail this form to the following address for a timely complaint/complaint appeal resolution:

CHRISTUS Health Plan

Appeal and Grievance Department

PO Box 169009

Irving, TX 75016

Fax# 1-866-416-2840

919 Hidden Ridge | Irving | TX 75038
Tel 844.282.3025 | Fax 210.766.8854 | ChristusHealthPlan.org