WEST REGION GRIEVANCE FORM

Use this form to file a grievance regarding a provider or services by TriWest Healthcare Alliance.

For grievances regarding a provider or services by TriWest Healthcare Alliance, return form to:

TRICARE West Grievances
P.O. Box 8930
Virginia Beach, VA 23450

Grievance Fax: 877-875-1305

For claims related issues, DO NOT USE this form.
Direct claims inquiries to:

TRICARE West Appeals
P.O. Box 2130
Virginia Beach, VA 23450

Claims Appeals Fax: 866-852-1994

First and Last Name of Involved Beneficiary:	Date of Birth (MM/DD/YYYY):	Sponsor SSN (XXX-XX-XXXX):

Beneficiary DoD Benefits Number (XXXXXXXXX-XX):	*Your First and Last Name:	Relationship to Beneficiary:

Daytime Phone Number:	Mailing Address:

City:	State:	ZIP Code:

** If you are not the involved beneficiary and the beneficiary is age 18 or older, the adult beneficiary may complete an Authorization to Disclose Information form (available on www.tricare.mil/west) so we may respond directly to you. If we do not have an Authorization to Disclose Information form on file we must respond directly to the adult beneficiary.*

Name of Provider or Department of Concern:	Date(s) of Incident(s):

Provider Phone Number:	Provider Mailing Address:

City:	State:	ZIP Code:

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information on behalf of the TRICARE® program, and how it will be used.

Authority: 10 U.S.C. Chapter 55; 38 U.S.C. Chapter 17; 32 CFR Part 199, and E.O.9397 (SSN), as amended.

Principal Purpose: To collect information from you in order to process the grievance, respond to the requestor and/or take action to correct deficiencies.

Routine Uses: Your information may be disclosed in order to investigate waste, fraud and abuse, security, and privacy concerns. Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/privacy/SORNs and as permitted by ther Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), and includes purposes of treatment, payment, and health care operations.

Disclosure: Voluntary; if you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays or the inability to process an individual's request.

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Describe concern(s): Please include what happened, when it happened and where it happened. Be specific about any statements made to you including the names of individuals who made the statements. Try to describe the events in the order in which they happened. You may attach additional pages or supporting documentation.	
Signature	Date (MM/DD/YYYY):