

Neighborhood Health Partnership Grievance Form

Member's name _____ Doctor _____

Address _____ Phone _____

NHP member ID number _____

SUMMARY OF GRIEVANCE

Have you contacted Neighborhood Health Partnership regarding this matter? _____

If yes, what was the result of this contact? _____

What can we do to help solve your problem? _____

Please mail this form to: Neighborhood Health Partnership, PO Box 5210, Kingston, NY 12402-5210

Member's signature _____ Date _____