ArrayRx PO Box 40168
Portland, OR 97240-0168

Uniform Medical Plan

Return this form by Mail or Fax:
ArrayRx Attn: Appeal Unit
PO BOX 40168
Portland OR 97240-0168
Fax: 1-866-923-0412

ArrayRx
COMPLAINT AND APPEAL FORM

Name of Person Filing Complaint Telephone#

Address City State **Zip**

Member Name Patient Name Member ID#

Name of Provider Involved Address Telephone#

Name of Provider Involved Address Telephone#

Date(s) of Service

Please write your complaint or appeal in the space below and on the back of this page. Attach additional pages if needed. You may include any document such as explanation of benefits (EOBs), correspondence, or invoices which will help us investigate your complaint or appeal. Please sign and date this form.

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Signature: ________________________________ Date: _ _ _ _ _ _ _ _ _ _ _ _ _ _

Upon receipt of your complaint or appeal, ArrayRx Services will mail you an acknowledgment letter.

Name of person filing Complaint/Appeal