Health Care Privacy Complaint Form

AmeriHealth Caritas VIP Care®

Use this form to file a complaint regarding the AmeriHealth Caritas VIP Care (HMO-SNP) privacy policies, procedures, and practices or compliance with our Notice of Privacy Practices or state and federal privacy rules and laws. You do not waive your state and federal privacy rights by filing a complaint. Filing a complaint will not influence your treatment, payment, enrollment, or eligibility for benefits. We will not retaliate against you for filing a complaint.

Section A: Individual filing the complaint

Last name:	First name:	Middle initial:	
Date of birth (MM/DD/YYYY):	Date of incident (if applicable):		
Address:	City:	State:	ZIP code:
Phone:	Contact hours (Please specify when you prefer to be called.):		

Insured's information (person whose name appears on the ID card):

Last name:	First name:	Middle initial:
Member ID number (from your ID card):		

Section B: Complaint

Please give a simple, concise explanation of the complaint.

Section C: Signature

I certify that the statements made in this complaint are true and correct to the best of my information and belief:

Signature:	Date:

If the complaint is lodged by a personal representative on behalf of the individual, complete the following and check the appropriate box.

Print name of personal representative:	
Signature of personal representative:	Date:

☐ Parent or legal guardian ☐ Power of attorney ☐ Executor ☐ Other:_____

Please return this form to: AmeriHealth Caritas VIP Care
Medicare Compliance
3875 West Chester Pike
Newtown Square, PA 19073

Processor's information (for internal use only)	
Name (please print):	Date:
Signature:	Date: