TriWest Healthcare Alliance
Department of Veterans Affairs (VA) Programs

Complaint/Grievance Form

Instructions:

If you have a Complaint/Grievance, TriWest would like to hear from you.
After completing this form please mail or fax it to:

TriWest Healthcare Alliance
Congressional Relations & Customer Grievances
PO Box 41970
Phoenix, AZ 85080-1970

Fax: (602) 564-2523

Your First Name:	Your Last Name:		
Relationship to Veteran: ☐Self ☐Family/Caregiver ☐Provider ☐Other:			
Your Telephone:	Your Email:		
VETERAN'S INFORMATION			
First Name:	Last Name:		
Date of Birth:	Last 4 of SSN:		
Telephone Number(s):	Choice Member ID:		
Email address (If applicable):			
Address:			
City:	State:	ZIP:	
COMPLAINT/GRIEVANCE INFORMATION			
Health Care Provider's Name (If applicable):			
Date(s) of Incident(s):			
Describe your concern(s): Please be as specific as possible about your concerns. We will contact you if more information is needed. You may attach additional pages or supporting documentation.			

Signature: _____ Date: _____

Thank you for submitting your concern(s). One of our representatives will be in touch with you within seven (7) business days from receipt of your concern.