Jackson Care Connect
Member Complaint/Feedback Form

Jackson Care Connect™
Part of the CareOregon Family

Your feedback is important to us. We want to fix this issue so it does not happen again. Thank you for sharing with us.

Your name: _____

Your phone number: _____

Member's name
(*if you are not the member*): _____

Member's OHP ID number and/or date of birth: _____

Please tell us what happened. (If you need more space, use the back of this form.)

_____

When did it happen?

_____

Who was involved?

_____

Please attach any documents that might help us look into the complaint.
Examples are: notices, denials of service, doctor bills or statements, letters or emails between the member and others, such as Department of Health Services, Oregon Health Authority, or Jackson Care Connect.

What do you want to happen now?

_____

Authorized representative information:

Name: _____ Age 18 or older: Yes ◯ No ◯

Organization: _____ Email: _____

Mailing address: _____

Phone number: _____ Signature _____

☐ Check if someone else is submitting this for you.

Submit finished form to:
CareOregon Attn: Grievance Coordinator
315 SW Fifth Ave Portland, OR 97204
Fax: 503-416-1313

Email: *customerservice@careoregon.org*

You can get this letter in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 503-416-4100 or TTY 711. We accept relay calls.