# Health Care Privacy Complaint Form

FirstChoice VIP CARE PLUS
by Select Health of South Carolina

Use this form to file a complaint regarding the First Choice VIP Care Plus (Medicare-Medicaid Plan) 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.

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**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:** First Choice VIP Care Plus
Medicare Compliance
3875 West Chester Pike
Newtown Square, PA 19073

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