



**Prudent Buyer HCO  
Provider Grievance Form**

**Name:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_  
**Current Address:** \_\_\_\_\_  
**Social Security Number:** \_\_\_\_\_  
**Name of Injured Worker:** \_\_\_\_\_  
**Claim Number:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_  
**Date of Injury:** \_\_\_\_\_  
**Insurance Company:** \_\_\_\_\_

**Nature of Grievance:**

(Describe the nature of the problem or complaint with specific dates if possible)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I am hereby filing a grievance in accordance with BCLH procedure.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date