CLEAR FORM

Member Complaint/Grievance Form

We want to help you resolve your complaint to your satisfaction as quickly as possible. Please mail us anything that may help us understand your complaint, along with your completed form to: **Community Eye Care (CEC), Attn: Complaint & Grievance, 4944 Parkway Plaza Blvd, Suite 200, Charlotte, NC 28217**. After receiving this form, you should hear back from us within 30 calendar days. If you have questions, please call Customer Service at 888-254-4290 or visit www.cecvision.com.

Section I – Your Information		
First and Last Name:	Member ID#:	
Mailing Address/PO Box:		
City:	State:	Zip Code:
Email:	Phone:	
Employer Name:		
Patient Name:		
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other		

Section II – Doctor Information		
Doctor Name:	Date of Service:	
Office Address:		
City:	State:	Zip Code:

Section III – Complaint/Grievance Information
Regarding: ☐ Doctor ☐ CEC ☐ Other
Description of the Complaint/Grievance:
How can we help resolve this?
May we use your name if we need to contact those referenced above about your comments? ☐ Yes ☐ No

Member Signature: _____ **Date:** _____