ADAP MEMBER PHARMACY SERVICES GRIEVANCE FORM

Date form sent to Ramsell:	Fax to: 800-848-4241	Mail to: 200 Webster St, Oakland, CA., 94607
Date of Occurrence:		
Time of Occurrence:		
Client phone number:	Client email address:	
E W Name:	Client ID, if ADAP Member :	
E W Number:	Pharmacy Name/Address :	

Nature of Concern	Outline below what occurred to cause you to file this grievance

Requested Resolution	Outline below how you would like to see the matter resolved

FOR RAMSELL PERSONNEL ONLY – GRIEVANCE NUMBER: _____

First level person Responsible:	Date Recvd:	Deadline:
Research / Action taken – indicate if considered resolved:		
If matter is not resolved, please indicate next steps:		
Second level person, if unresolved:	Date Recvd:	Deadline:
Research / Action taken:		