MAJORIS™

Dispute / Complaint Form

Patient's Name _____

Claim Number _____

Date of Disputed Action _____

Person submitting information:

Name: _____

Address: _____

_____

Phone: _____

Please provide the details you would like us to consider in reviewing your dispute and/or complaint. You may write on the back and front of this form, and also include attachments you feel would add to your case.

Please submit to:

Majoris Health Systems, Inc.
Employee Complaint Department
PO Box 1728
Lake Oswego, OR 97035
503-639-6080
email: info@majorishealthsystems.com