[DATE]

[PROVIDER NAME]

[CLINIC NAME]

[STREET ADDRESS]

[CITY, STATE ZIP]

# Re: Grievance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Dr. [Provider Name]:

IEHP has concluded its review of your provider grievance filed [Date] regarding [state reason here] and has determined the following:

Thank you again for bringing your concerns to IEHP’s attention so that we may best serve the needs of our providers and Members.

Please contact me at (909) 890-XXXX if you have any further questions or concerns.

Sincerely,

[Director Name]

Director of Provider Relations, IEHP

cc: Manager Name, Manager of Provider Relations, IEHP

 PSR Name, Provider Services Representative, IEHP

 PCP

 IPA

 File location (see policy and procedures PRO/GEN 03) ex. F-120.a