

Provider Directory Error Report Form

Member/Perspective Member Information

Date: _____

I would like to report an inaccuracy within the Provider Directory.

Name: _____
(First) (Middle) (Last)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Email: _____

Provider Information

Type of Inaccuracy:

- | | | |
|--|--|--|
| <input type="checkbox"/> Address | <input type="checkbox"/> Office is closed to New Members | <input type="checkbox"/> Telephone |
| <input type="checkbox"/> Provider is no longer there | <input type="checkbox"/> No longer accepting VCHCP | <input type="checkbox"/> Email Address |
| <input type="checkbox"/> Other: _____ | | |

Provider Information:

Name of Group/Individual Provider: _____

Practice Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Email: _____

This form may be submitted online, emailed, mailed, or faxed to VCHCP Provider Services/Provider Relations at:

vchealthcareplan.org/members/ProviderDirectoryErrorReportForm.aspx

VCHCP.ProviderServices@Ventura.org

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Phone: (805) 981-5050 or (800) 600-8247

Fax: (805) 981-5051.