

## **ADA-Related Service Complaint Process**

Copa Health, Inc. welcomes comments, compliments, and complaints from its members on their experiences using Copa Health, Inc. services. Member input helps identify areas needing improvement, and commendations are always appreciated.

All member complaints are carefully reviewed, and those submitted by members who experience accessibility or ADA-related problems are additionally reviewed for adherence to Copa Health, Inc.'s policies by the Vice President of Compliance and Quality Management.

To file an ADA-related service complaint, members may contact Copa Health, Inc. using any of the following methods:

- **Mail**  
Copa Health, Inc.  
Corporate Compliance Department  
924 N Country Club Drive  
Mesa, AZ 85201
- **Phone**  
480.969.3800
- **Email**  
Andrew.Terech@CopaHealth.org

Copa Health, Inc. will investigate the complaint and promptly communicate a response to the member within 10 business days.

All submittal methods will result in the Corporate Compliance department receiving the complaint information and entering it into the member comment database, which documents every complaint received and all related follow-up activities. Members with an ADA-related complaint will receive a complaint confirmation/tracking reference number, usually within the same day but no later than ten (10) business days from the day Copa Health, Inc. receives the complaint. If the member does not receive a response within the ten (10) day timeframe, s/he can call the Corporate Compliance Department at 480.969.3800 to obtain the confirmation/tracking reference number.

The Copa Health, Inc. Corporate Compliance department investigates all complaints and implements any corrective actions to be taken. Complaints involving ADA or accessibility elements receive an additional review by the Vice President of Compliance after the investigation has been completed. After the ADA compliance oversight review has been completed, a written reply will be provided to the member at the contact address provided within ninety (90) days of receiving the complaint. All complaints are investigated within a few weeks, but some may require more extensive investigation, or require more time to identify corrective measures. In any case, a written reply will be provided to the member within ninety (90) days.

Whether our members are submitting complaints about service problems or sharing a great experience, we welcome the opportunity to be of service.

Copa Health, Inc.

**Americans with Disabilities Act  
and Section 504 of the Rehabilitation Act of 1973  
Discrimination Complaint Form**

Instructions: If you believe Copa Health, Inc. has engaged in discrimination against one or more persons based on medical condition or disability, please fill out this form completely, sign, and return to the address on the next page.

Alternative means of filing complaints, such as personal interviews or a tape recording of the complaint will be made available for persons with disabilities upon request. Call 480.969.3800 for assistance. Please request the Corporate Compliance Department.

Name of Complainant: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Person Discriminated Against:  
(if other than the complainant) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

What date did the discrimination occur? \_\_\_\_\_

Describe the acts of discrimination providing the name(s) where possible of the individuals who discriminated (use additional space on the next page if necessary):

Has a complaint been filed with another bureau of the Department of Justice or any other Federal, State, or local civil rights agency or court?    Yes \_\_\_ No \_\_\_

If yes, Agency or Court: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date Filed: \_\_\_\_\_

Additional space for answers:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please Return Form to:

**ADA Compliance  
Attn: Corporate Compliance Department  
Copa Health, Inc.  
924 N Country Club Dr.  
Mesa, AZ 85201**

**or by email at [Andrew.Terech@CopaHealth.org](mailto:Andrew.Terech@CopaHealth.org)**

Phone: 480.969.3800