VENTURA COUNTY
HEALTH CARE PLAN

# Error Report Form

## Member/Perspective Member Information

**Date:** _____

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

First Name: _____

Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Email: _____

## Provider Information

**Type of Inaccuracy:**

□ Address □ Office is closed to New Members □ Telephone

□ Provider is no longer there □ No longer accepting the Plan □ Email Address

□ Other: _____

**Provider Information:**

Name of Group/Individual Provider: _____

Practice Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Email: _____

Please email, mail, or fax this change form and supporting documentation to: Provider Services Department at VCHCP.ProviderServices@Ventura.org; 2220 E. Gonzales Rd. #210-B, Oxnard, CA. 93036; Fax: 805-981-5051.