Patient Complaint Form

Patient Name: ____________________________________Date/time:____________________________

Address: __________________________________ City: __________________________ State_______

Telephone: ____________________ Medicare/Health Insurance Claim No:__________________________

Complaint (include date complaint occurred): ____

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Signature: _______________________________________

Do not write below this line- to be completed by facility

Action taken to resolve complaint:

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By: ____________________________________ Date/Time: _________________________________

Comments (Is there a need to change protocols or processes based on this investigation?):

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