

Patient Complaint Form

Fatient Complaint Form						
Name of Patient			Patient Phone Number:	Date	of Event	Date Complaint Filed
Patient Address:			Name of Individual Filing Complaint:		Health Insurance Company:	
Complaint filed by: Patient Caregiver Responsible Party/POA Health			care Professional		May we contact you regarding your concerns? ☐Yes ☐No	
Type of Complaint						
Customer Service/Training Delivery of Service Billing Continuity of Care HIPAA Privacy/Security Other:						
Description of Complaint:						
Phone Number:	Pri	int Nam	ne:			
Email Address:	Sig	gnature	»:			
Effective Date: August 30, 2016			Mail to: 1333 Plank Road Ste 200 Du	ıncansv	ille, PA 1663	5 or Fax to: 814-283-2211