



**CUSTOMER GRIEVANCE/COMPLAINT FORM**

Caller's Name: \_\_\_\_\_ Expecting Call Back Yes • No •

Caller's Phone Number: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

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

Employer Group: \_\_\_\_\_

Name of Insurance Company or TPA: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Contact at Facility: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Complaint: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Follow-up: \_\_\_\_\_ Type of Resolution Desired: \_\_\_\_\_

Writing: • \_\_\_\_\_

Phone Call: • \_\_\_\_\_

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

Call Taken By: \_\_\_\_\_ Date: \_\_\_\_\_

Referred To: \_\_\_\_\_ Date: \_\_\_\_\_