## COMPLAINT FORM

**Patient’s Name: \_\_\_\_**

**Phone Number: Date/Time Received: \_\_\_\_\_**

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

**Patient's Medicare/Medicaid or Health Insurance Claim Number: \_\_\_\_\_**

**Date/Time of response to patient: \_\_\_\_\_**

**Date of written notification to patient: \_\_\_\_\_**

**Employee Receiving Concern: \_\_\_\_\_**

**Describe Complaint or Concern: (Use additional sheets as needed) (Attach documentation of response(s) and copies of written communication to the patient)**

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **E-mail completed form to ASC Executive Director Faith Allard @ admin@alaskasleep.com**