



Compliment, Complaint, Grievance Form

I. General Information				
Information Received By:	Name	Title	Date	Time
Type: (X)	Compliment	Complaint	Grievance	
Method of Communication: (X)	Letter	Fax	E-mail/Web site	Verbal
Form Completed By: (if other than InteCare Staff)	Print Name:		Signature:	
Communication Source:	<input type="checkbox"/> Consumer		<input type="checkbox"/> Individual Provider	
	<input type="checkbox"/> Family Member		<input type="checkbox"/> Organization/Facility/Member Provider	
	<input type="checkbox"/> Friend		<input type="checkbox"/> Employer	
	<input type="checkbox"/> Attorney		<input type="checkbox"/> Consumers' Primary Care Physician	
	<input type="checkbox"/> Government Agency		<input type="checkbox"/> InteCare Staff and/or Network and Credentialing Subcommittee	
	<input type="checkbox"/> EAP			
	<input type="checkbox"/> Client/Account		<input type="checkbox"/> Other: _____	
	Name:		Phone#:	
	Address: _____		E-Mail: _____	
	_____		Fax: _____	
	_____			
	Client/Account: _____			
	Name of Practitioner	Location	Name of Organization/Facility	Name of Program



## II. Statement Type

### Access & Availability of Provider and/or Network Services: (check all that apply)

- Appointment availability regarding length of time to appointment from day/time of initial call
  - Geographic location of provider is too far to travel and/or inconvenient
  - Telephonic responsiveness of Provider
  - Appointment availability regarding length of time between initial appointment and subsequent appointments
  - Other: (please explain) \_\_\_\_\_
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### Quality of Network Services and Provider Location: (check all that apply)

- Requesting a different Provider due to: (check which aspect applies to complaint)
    - Provider does not appear to possess expertise/specialty to assist Consumer with stated issues
    - personality conflict and/or not connecting with Provider
    - difficulty in getting to appointments regarding location and/or scheduling of appointment
    - not seeming interested in Consumer's issues and/or not helpful in meeting treatment goals
    - Consumer not satisfied with overall treatment experience
  - Provider behavior and/or attitude is unprofessional
  - Provider disclosed Protected Health Information without proper authorization/violated confidentiality
  - Physical office environment and/or surroundings are unsatisfactory
  - Office location is not physically accessible
  - Provider administrative staff (receptionist, billing, etc.) conduct unprofessional and/or discourteous
  - Other: (please explain) \_\_\_\_\_
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### InteCare Corporate Administrative Issues: (check all that apply)

- Billing issues – e.g. billing error, inaccurate information
  - Claims processing – e.g. timeliness of payment, payment error
  - Promptness of addressing identified issues
  - Staff unprofessional and/or unresponsive
  - Protected Health Information Issues – e.g. Covered individual believed PHI was shared without appropriate authorization
  - Unresponsive in dealing with inquiry
  - Credentialing Process
  - Provider Application Process and/or turnaround time
  - Timeliness of Appeal Process
  - Telephonic responsiveness of InteCare Corporate Office
  - Other: (please explain) \_\_\_\_\_
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### Quality Of Care: (check all that apply) Must also complete the Quality Of Care Review Form and Follow the Process Outlined in the Quality Of Care Procedure)

- Adverse incident or event regarding:
  - Suicide attempt
  - Drug overdose
  - Death
  - Homicide
- Treatment recommendations seen as harmful and/or dangerous
- Provider/Staff unprofessional and/or unethical conduct
- Identified concerns from Network and Credentialing Subcommittee review regarding Provider Credentialing/Recredentialing



