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:	☐ **Consumer** ☐ **Family Member** ☐ **Friend** ☐ **Attorney** ☐ **Government Agency** ☐ **EAP** ☐ **Client/Account** ☐ **Individual Provider** ☐ **Organization/Facility/Member Provider** ☐ **Employer** ☐ **Consumers' Primary Care Physician** ☐ **InteCare Staff and/or Network and Credentialing Subcommittee** ☐ **Other:**_____ **Name:** **Phone#:** **Address:**_____ **E-Mail:**_____ _____ _____ **Fax:**_____ _____ **Client/Account:**_____

	Name of Practitioner/Staff	**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/Staff
- ☐ Appointment availability regarding length of time between initial appointment and subsequent appointments
- ☐ Other: (please explain) _____

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☐ **Quality of Services and Location: (check all that apply)**

- ☐ Requesting a different Provider/Staff due to: (check which aspect applies to complaint)
  - ☐ Provider/Staff does not appear to possess expertise/specialty to assist Covered Individual/Individual Served with stated issues
  - ☐ personality conflict and/or not connecting with Provider/Staff
  - ☐ difficulty in getting to appointments regarding location and/or scheduling of appointment
  - ☐ not seeming interested in Covered Individual/Individual Served's issues and/or not helpful in meeting treatment goals
  - ☐ Covered Individual/Individual Served not satisfied with overall treatment experience
- ☐ Provider/Staff behavior and/or attitude is unprofessional
- ☐ Provider/Staff disclosed Protected Health Information without proper authorization/violated confidentiality
- ☐ Physical office environment and/or surroundings are unsatisfactory
- ☐ Office location is not physically accessible
- ☐ 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 Covered Individuals receiving Clinical Treatment:
  - ☐ 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

☐Compliment	☐Complaint	☐Level One Appeal	☐Grievance

Please be specific in your description – include dates, times, location and sign and date notation. If you require additional space, please attach comments.

Name of Individual(s) Form Sent to for Review and/or Resolution:	Date Forwarded:

Resolution RE:	☐Complaint	☐Level One Appeal	☐Grievance

Please describe in detail the attempts to Resolve the Complaint or Grievance, and sign and date notation. If you need additional space, please attach comments:

Date Communicated with Complainant/Appellant/Grievant: (Please note: if Level One Appeal or Grievance, attempt to resolve complaint will be communicated by InteCare Staff)	
Is the Complainant/Appellant/Grievant Satisfied with the Attempts to Resolve Their Complaint?	☐ **Yes** ☐ **No** ☐ **Unknown**
Date Completed Form Sent Back to InteCare: (if completed by Provider Organization)	
Date Complaint/Appeal/Grievance Closed: ("Closed" is defined as all attempts were made to resolve the complaint to the satisfaction of the Client, and that they are either satisfied with the resolution, or do not/have not initiated a level one appeal or grievance. InteCare, Inc. recognizes that there are situations in which a satisfactory resolution may not be possible; therefore the issue may be "closed" but the Client will not be satisfied with the resolution).	

Cc: Organization/Facility File
Provider File
Complainant/Appellant/Grievant File