MEDICARE QUALITY OF CARE COMPLAINT FORM

INFORMATION TO HELP YOU FILL OUT THE "QUALITY OF CARE COMPLAINT" FORM

The Medicare Program works to ensure that beneficiaries get the best care possible. We take your concerns seriously and would like to get more information to help us review your request. Use of this form will ensure that we process your concerns in an efficient manner. Quality Improvement Organizations (QIOs), under contract with Medicare, are required to conduct reviews of all written complaints from beneficiaries about the quality of services not meeting professionally recognized standards of health care. You may contact the QIO for assistance in completing this form or for general assistance regarding your complaint.

Please use this step-by-step instruction sheet when completing your "Quality of Care Complaint" Form. Be sure to complete all sections of the form. In addition, if your personal information has been included in the form based on contact you have had with the QIO for your state, please review the information to confirm its accuracy.

1. Print the name of the Medicare beneficiary who has a complaint about the quality of health care he/she received.

2. Include the Beneficiary's Medicare (HICN) number if known.

3. Check the appropriate box designating the sex of the individual listed in number 1. In addition, please indicate the age of the beneficiary in the blank space provided, if known.

4. Check the appropriate box or boxes indicating the race/ethnicity of the individual listed in number 1. Please note that this information is strictly voluntary and has no impact on the processing of the complaint.

5. Print the name of the beneficiary's authorized representative if someone other than the beneficiary will be the contact for the processing of the complaint.

6. Print the contact information for the beneficiary or for the beneficiary's authorized representative someone other than the beneficiary will be the contact for the processing of the complaint.

7. Provide a brief description of the incident or concern. The description should include any information you believe is relevant to the review of your complaint, including:

   - dates and times,
   - physicians and provider staff involved,
   - information from witnesses if available, and
   - a description of what happened. If you require more space to describe your complaint, you may attach additional sheets of paper. In addition, you may provide any documents you believe support your complaint.

Please note: If you raise concerns that are not quality of care concerns within the scope of the QIO's authority, your complaint will be referred to the appropriate entity.

1. By signing the form, you are authorizing the QIO to review your complaint and render a formal determination. The processing of your complaint may require the requesting of pertinent medical records.

2. PLEASE keep this page for your information. Only mail the second page (Medicare Quality of Care Complaint Form) to the QIO. The phone number of your QIO is 1-866-815-5440. A decision on your complaint will be made within 185 days of receiving the signed complaint form.

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1. BENEFICIARY NAME:

2. MEDICARE NUMBER (HICN):

3. SEX: ☐ **MALE** ☐ **FEMALE**	**DATE OF BIRTH:**

4. RACE/ETHNICITY *(Completion of this section is voluntary) How would you describe your race? Please mark one or more boxes.*
How would you describe your race? Please mark one or more boxes.

☐ American Indian or Alaska Native ☐ White ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Hispanic or Latino

5. BENEFICIARY'S AUTHORIZED REPRESENTATIVE'S NAME *(IF APPLICABLE)*:

6. CONTACT INFORMATION FOR PRIMARY CONTACT:

STREET/APT.

CITY	**STATE**	**ZIP**
PHONE	**ALTERNATE PHONE**	

7. Briefly describe the incident or your concerns: Include dates and times, persons involved, and description of what happened. Include attachments, if appropriate.

8. May we reveal your identity during the review of your complaint? ☐ YES ☐ NO
If you check "no" we cannot review your complaint as a written beneficiary complaint. However, based on the circumstances of your complaint, we may choose to review your complaint as a general quality of care review.

9. Check "yes" here if you authorize the QIO to forward your address or other contact information to the entity that conducts beneficiary satisfaction surveys. If you check "yes", you will be contacted by telephone or postal mail to conduct a brief survey about your satisfaction with the service you received from the QIO. **If you leave this question blank, a surveyor will contact you about your satisfaction.** ☐ YES ☐ NO

FOR YOUR INFORMATION: If you have any questions about your complaint, please call 1-866-815-5440. You will be contacted within 1 bu days upon the QIO's receipt of the signed complaint form. The QIO will utilize a physician who practices in the same or similar clinical area as the physician who provided your care in completing its review. You may provide any information you believe is relevant to your complaint, including copies of documentation, names of witnesses, etc. A decision will be made on your complaint within 185 days of receiving the signed complaint form. If your complaint includes concerns not within the scope of the QIO's authority, the concerns will be referred to the appropriate entity.

10. By signing this form, I am requesting that the QIO review my complaint.

SIGNATURE OF BENEFICIARY OR REPRESENTATIVE	DATE