

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.
8. Check the appropriate box indicating whether you would like the physician or provider who is the subject of your complaint to know that you have filed a complaint with the QIO about the care you received. The QIO will not reveal your identity if you check “No.”
 9. 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.
 10. 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 (800) 365-5899**. You may also **fax** the second page to **1 (800) 465-7431**. A decision on your complaint will be made within 150 days of receiving the signed complaint form.

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1. Beneficiary Name:		
2. Medicare # (HICN):		
3. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Age: _____		
4. Race/Ethnicity (Completion of this section is voluntary): How would you describe your race? Please mark one or more boxes. <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino		
5. Beneficiary's Authorized Representative's Name (If applicable):		
6. Contact Information:		
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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
For your information: <ul style="list-style-type: none"> • If you have any questions about your complaint, please call 1-800-365-5899. • You will be contacted within one day 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 150 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. 		
9. By signing this form, I am requesting that the QIO review my complaint.		
Signature of Beneficiary/Representative:		Date: