North Alabama Commuity Care

Grievance Procedure Processing Form

Section I – Client

Doctor: _____ New Doctor: _____

Care Coordinator: _____ New Coordinator: _____

Patient's Name: _____

Medicaid number: _____

Phone number: _____

Address: _____

Transfer Date: _____

Next appointment date with doctor: _____

Enrollment Date: _____

Statement of Incident, Problem or Complaint:

_____

_____

_____

_____

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_____

_____

Client Signature: _____ Date: _____

Section II – Care Coordinator

Action Taken to Resolve Grievance:

_____

_____

_____

_____

Request Denied _____ Request Approved _____

Care Coordinator Signature: _____ Date: _____