Grievance Procedure Processing Form

Section I – Client

Doctor: _____ New Doctor: _____

Patient's Name: _____

Medicaid number: _____

Social security number: _____

Phone number: _____

Address: _____

Transfer Date: _____

Appt date with new DHCP _____

Enrollment Date: _____

Statement of Incident, Problem or Complaint:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Client Signature: _____ Date: _____

Section II – Care Coordinator

Action Taken to Resolve Grievance:

_____

_____

_____

_____

Request Denied _____ Request Approved _____

Care Coordinator Signature: _____ Date: _____

Compliant/Grievance can be mailed to:

Best Start
3304 Westmill Road
Huntsville, AL 35806
Attn: Grievance Coordinator