Complaint Form

Date Submitted: ____________________ Facility Representative: ___________________

Facility Name:______________________ Facility Contact Number: __________________

Member/Patient's Name:____

Medicaid Number:____

Date of Appointment:____

Appointment Time:____

Who Transported Member/Patient: ____

Complaint Description:____

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FAX TO 877-601-0620

Modivcare *Solutions, MDC Office Use ONLY*

Date Fax Received: ___________________ Date Fax Returned: __________________

Date Complaint Entered:________________ Date Complaint Closed: _______________

Entered By:____________________________

Complaint Number:_______________________