modivcare

COMPLAINT FORM

Date Submitted: _____ By: _____

Facility: _____ Facility Phone Number:_____

Member/Patient's Name: _____

Medicaid Number: _____

Date of Appointment: _____

Appointment Time: _____

Who Transported Member/Patient: _____

Complaint:

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Your Recommendation:

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FAX TO: 866-420-6253, Attn: Dayna Holford

Date Fax Received: _____ Date Fax Returned _____

Date Complaint Entered: _____ Date Complaint Closed: _____

Entered By: _____ Date Complaint Closed: _____

Complaint Number: _____

Revised 06/11