MEDICARE BENEFICIARY COMPLAINT LOG

Date of receipt of complaint: _____

Patient's name: _____

Patient's address: _____

_____ State _____ Zip code _____

Patient's telephone number: _____

Patient's Medicare or Health Insurance Claim Number: _____

Description of complaint: _____

_____

_____

_____

Action taken to resolve the complaint: _____

_____

_____

_____

_____ _____

Signature of representative Date

_____ _____

Please email your completed form to Compliance@alixarx.com