



Complaint Reporting Form

Contact Information

Name:	DOB:
Telephone #:	Address:

Please provide the specific details of your complaint (Date/ time/ location/ people involved):

What do you hope will happen as a result of your complaint?

X

Complainant Signature

Return by mail:

AccelHealth
ATTN: Director of Compliance and Quality
1100 W. Reynosa Ave.
DeLeon, TX 76444

Internal use only
Date received:
Complaint Recipient:
<i>Please send complaint to the appropriate department supervisor for review.</i>

