

Complaint Reporting Form

Contact Information

| Name: | DOB: |
|--|--|
| Telephone #: | Address: |
| Please provide the specific details of your compla | int (Date/ time/ location/ people involved): |
| | |
| | |
| What do you hope will happen as a result of your | complaint? |
| | |
| | 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: | | | |
| Please send complaint to the appropriate | | | |
| department supervisor for review. | | | |



Complaint Action Form

To be completed by AccelHealth staff

Attach the accompanying complaint reporting form

| Action Taken: | | | | | |
|---------------|------|------|------|--------------|--|
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Director of Compliance/ Date

Complaint Recipient/ Date