

Pinnacle Medical Supplies

Please return the survey to Pinnacle Medical Supplies in the envelope provided.
Thank you for choosing Pinnacle Medical Supplies.

Form Revised: 06/25/2022

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VERSION 2022.3

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COMPLAINT FORM

Patient: _____

Phone Number: _____ **Date/Time Received:** _____

Address: _____

Patient's Medicare/Medicaid or Health Insurance Claim Number: _____

Date/Time of response to patient: _____

Date of written notification to patient: _____

Employee Receiving Concern: _____

Describe Grievance, Complaint or Concern: (Use additional sheets as needed) (Attach documentation of response(s) and copies of written communication to the patient)

Administrative Action:

Resolved By: _____ **Date:** _____

PINNACLE MEDICAL SUPPLIES COMPLAINT LOG

Month _____ Year _____

Date & Time Rec'd	Patient Name	Complaint Type	Date Called	Date Resolved	Date Letter Mailed
		<input type="checkbox"/> Delivery Concern <input type="checkbox"/> Equipment Failure <input type="checkbox"/> Supply Concern <input type="checkbox"/> Other-			
		<input type="checkbox"/> Delivery Concern <input type="checkbox"/> Equipment Failure <input type="checkbox"/> Supply Concern <input type="checkbox"/> Other-			
		<input type="checkbox"/> Delivery Concern <input type="checkbox"/> Equipment Failure <input type="checkbox"/> Supply Concern <input type="checkbox"/> Other-			
		<input type="checkbox"/> Delivery Concern <input type="checkbox"/> Equipment Failure <input type="checkbox"/> Supply Concern <input type="checkbox"/> Other-			
		<input type="checkbox"/> Delivery Concern <input type="checkbox"/> Equipment Failure <input type="checkbox"/> Supply Concern <input type="checkbox"/> Other-			
		<input type="checkbox"/> Delivery Concern <input type="checkbox"/> Equipment Failure <input type="checkbox"/> Supply Concern <input type="checkbox"/> Other-			
		<input type="checkbox"/> Delivery Concern <input type="checkbox"/> Equipment Failure <input type="checkbox"/> Supply Concern <input type="checkbox"/> Other-			