PATIENT GRIEVANCE FORM

All patient grievances are confidential & will be forwarded to Administration.

PERSON REGISTERING THE GRIEVANCE

Name: _____
Last First MI

Patient name (if different than above): _____
Last First MI

Patient Date of Birth: _____ Relationship to Patient: _____

Are you a Medi-cal Managed Care Patient? YES NO

If so, which plan? (circle one) Anthem Blue Cross CalViva Health Net

Please circle one - Scheduled Appointment Walk In

NATURE OF GRIEVANCE

Name of Staff(s) Involved: _____

Please check which clinic the grievance occurred:

- ☐ Clovis
- ☐ Bullard
- ☐ Behavioral Health Service
- ☐ Tachi
- ☐ Prather
- ☐ North Fork

Please check department(s) involved:

- ☐ Medical Front Office
- ☐ Medical Back Office
- ☐ Dental Front Office
- ☐ Dental Back Office
- ☐ Referrals
- ☐ Billing
- ☐ Optical
- ☐ PRC
- ☐ Outreach
- ☐ Nutrition
- ☐ COVID Team

Date, Time & Describe reason for grievance: