PATIENT CONCERNS/GRIEVANCES FORM

MCC Apothecary staff strives to ensure quality products/services that are consistent with our philosophy. As stated in your Bill of Rights and Responsibilities, you have the right to be given appropriate and professional quality home care services without discrimination. You also have the right to voice your concerns, grievances, or complaints about your service without being threatened, restrained or discriminated against.

If you are unhappy with our service or have concerns about safety and quality of care, we would like you to contact our management. You may either complete this form or call us at the number listed below or visit our website at www.montgomerycancercenter.com to submit your concerns or by calling 833-247-9052.

Within 5 calendar days of receiving your concern, we will notify the beneficiary by using telephone, email, fax or letter format that the matter is under investigation. Within 14 calendar days, the organization will provide written notification to the beneficiary with the results of its investigation and response. Mail form to:

MCC Apothecary
4145 Carmichael Road
Montgomery, AL 36106

Thank you in advance for bringing your concern to our attention as it will assist us in our continuing effort to improve the quality of our services.

Commitment to Excellence: Montgomery Cancer Center is accredited by the Accreditation Commission for Health Care (ACHC) for compliance with a comprehensive set of national standards. By choosing a healthcare provider that has achieved ACHC accreditation, you can take comfort in knowing that you will receive the highest quality of care. If you have any concerns about the product or service that you receive from Montgomery Cancer Center, you may contact ACHC directly at (855) 937-2242.

Patient's Name:_____ DOB:_____

Description of the problem/concern/complaint (include dates, times and names, if possible):

_____

_____

_____

Completed by (signature):_____ Date: _____ Relationship to patient (if applicable): _____

(FOR OFFICE USE ONLY)

Patient's Address: _____

Patient's Telephone Number: _____

Patient's Medicare or Health Insurance Claim Number: _____

Date Received: _____ by: _____

Follow-up by phone completed by: _____ Date:_____Time: AM/PM

Items discussed: _____

Resolution/Action taken to resolve the complaint: _____

Follow-up by letter completed by: _____ (please attach copy)

Date completed:_____ Date mailed: _____ Form completed by: _____ Date:_____