



MEDICARE BENEFICIARY COMPLAINT LOG

Date of receipt of complaint: _____
Mail _____ or Telephone _____

Patient's name: _____

Patient's address: _____
State: _____ Zip code: _____

Patient's telephone number: _____

Patient's Medicare Number: _____
Patient's Account #: _____

Type of complaint: Billing _____ Service _____ Equipment _____ Other _____

Description of complaint:

Action taken to resolve the complaint:

Does complaint need to go to next level? _____
If so, to whom? _____ Date to next level: _____

Has patient been notified and complaint resolved? _____

Signature & Title of JACE representative: _____
Date Resolved: _____