

**PATIENT CONCERNS / GRIEVANCES FORM**

Decillion Healthcare’s 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 614-389-8371/800-622-9321 or visit our website at [www.DecillionHealthcare.com](http://www.DecillionHealthcare.com) to submit your concerns under the contact us page. You may report concerns about safety or the quality of care to The Joint Commission without retaliatory action from Decillion Healthcare by contacting The Joint Commission at their toll free telephone number 800-994-6610 from 8:30 AM to 5:00PM, Eastern Time or at [www.jointcommission.org](http://www.jointcommission.org). You may also report concerns about your provider, medication and durable medical equipment to Medicare at 1-800-MEDICARE (800-633-4887).

Within 5 calendar days of receiving your concern, we will notify the beneficiary by using telephone, email, and 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:** Decillion Healthcare

270 Cramer Creek Ct.

Dublin, Oh 43017

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.

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:

NP19: Rev 2/25/14

 [**www.DecillionHealthcare.com**](http://www.DecillionHealthcare.com)