ALABAMA MEDICAID AGENCY
PLAN FIRST/FAMILY PLANNING PROGRAM
COMPLAINT/GRIEVANCE FORM

**Note: For reporting complaints regarding Plan First/Family Planning Services Only*

The Alabama Medicaid Agency (Medicaid) Plan First/Family Planning staff reviews all complaints that come to our office. We take each complaint seriously and have a process in place to address them. If you have a complaint or grievance about the service(s) you received or the doctor who provided the service (s), please complete the form and mail it to the following address: **Alabama Medicaid Agency, Managed Care Division, Plan First/Family Planning Program_501 Dexter Avenue Suite 7000_Montgomery, AL 36103**

Name of Person Completing this Form: _____
May be the recipient, designated friend/family member, medical provider, hospital, community member, etc.)

Date Form Completed: _____ Relationship to Recipient: _____

Recipient's Name: _____ **DOB: _____**

Recipient's Medicaid Number: _____ **County of Residence**: _____

Address: _____

Telephone Number: _____

Name of Doctor: _____ Name of Practice: _____

Please describe your complaint in detail including dates/names

(please attach any additional documentation)

_____

_____

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_____

Over (See Consent Statement and Signature)

It is not necessary for Medicaid to use your name when investigating a complaint. However, it is more effective if your names if used when describing the concern to the provider.

Section I.

If you agree for Medicaid to use your name in investigating this complaint, complete Section I.

I give Medicaid permission to use my name when sharing my complaint with the Plan First/Family Planning Provider named in my complaint. The Plan First/Family Planning Provider has my permission to respond to Medicaid concerning my complaint and release medical records if requested by Medicaid.

_____ _____

Signature of Complainant Date

_____ _____

Signature of Patient/Parent/Legal Guardian Date

OR

Section II.

If you would like your name to remain confidential and you DO NOT want Medicaid to use your name in the investigation of this complaint, complete Section II.

_____ _____

Signature of Complainant Date

_____ _____

Signature of Patient/Parent/Legal Guardian Date

PLEASE DO NOT SIGN BOTH STATEMENTS.

If you have any questions about the use of this form or the Plan First/Family Planning complaint process, please contact the Plan First/Family Planning staff at 334-242-5693 or 334-353-9404. *Thank you for giving us this opportunity to serve you better.*

Do Not Write Below This Line

Plan First/Family Planning Provider Name: _____ NPI #: _____

Plan First/Family Planning Practice Name: _____

Plan First/Family Planning Practice County Location: _____

Comments:

_____

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