

Medicare Quality of Care Complaint Form

Quality Improvement Organizations (QIOs) are authorized by Medicare to review Medicare quality of care complaints. Use this form to share details of your complaint with the QIO.

Patient name _____

Medicare number _____

Sex

☐ Male

☐ Female

Date of birth (mm/dd/yyyy) _____

Patient's Authorized Representative name (if applicable): _____

Contact information for primary contact

Street/Apt. _____

City _____

State _____

ZIP code _____

Phone _____

Alternative phone _____

Email address _____

Briefly describe the incident or your concerns: Include dates and times, persons involved, and description of what happened. You can include any attachments you believe are relevant to your complaint, including copies of documentation, names of witnesses, etc.

Paperwork Reduction Act: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1102. This is a voluntary information collection to obtain a benefit. The time required to prepare and distribute this collection is 10 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ****CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Beneficiary and Family Centered Care (BFCC)-QIOs. Contact information may be found at: <https://www.cms.gov/medicare/quality/quality-improvement-organizations/family-centered-care>

Can we reveal your identity when we review your complaint? ☐ Yes ☐ No If you check “no,” we can’t review your complaint as a patient complaint. Depending on the circumstances of your complaint, we may decide to review your complaint as a general quality of care review.

Can we forward your contact information for the purpose of a patient satisfaction survey? ☐ Yes ☐ No
If you check “yes” or leave this question blank, a surveyor will contact you with a brief survey about your satisfaction with the service you got from the QIO.

By signing this form, I’m asking the QIO to review my complaint

Signature of patient or representative

Date (mm/dd/yyyy)

For your information:

If you have any questions about your complaint, please call _____. You will be contacted within ____ days upon the QIO’s receipt of the signed complaint form. The QIO will utilize a physician who practices in the same or similar clinical area as the physician who provided your care in completing its review. You may provide any information you believe is relevant to your complaint, including copies of documentation, names of witnesses, etc. A decision will be made on your complaint within ____ days of receiving the signed complaint form. If your complaint includes concerns not within the scope of the QIO’s authority, the concerns will be referred to the appropriate entity.

Get help & more information

For help completing this form or questions about your complaint, call _____.

Your complaint will be reviewed by a physician who practices in the same or similar clinical area as the physician who provided your care. If your complaint includes concerns the QIO doesn’t have authority to review, we’ll refer those concerns to the appropriate organization.