Complaint Form

I am filing this complaint as a: (please check one box below)

☐ **Patient** – individuals who receive medical services from an organization or provider that participates in the PelEX

☐ **Member Organization** – a provider organization that participates in the PelEX

☐ **Other –** please explain below:

_____

I wish to file this complaint anonymously. (NOTE: If you select yes, please DO NOT fill out any of the identifying contact information in the section below.)

☐ Yes ☐ No

Contact Information

First Name: Click or tap here to enter text.

Last Name: Click or tap here to enter text.

Preferred contact method: (please check one box below)

☐ **Phone Number:** Click or tap here to enter text.

☐ **Email Address:** Click or tap here to enter text.

☐ **Mailing Address:** Click or tap here to enter text.

Can we contact you for additional information if necessary?

☐ Yes ☐ No

Would you like to be notified of a resolution to this complaint?

☐ Yes ☐ No

Partnerships for Achieving Total Health d/b/a PelEX
400 Poydras Street, Ste 1250
New Orleans, LA 70130

Description of Complaint

What best describes your complaint? (please check one box below)

☐ Privacy ☐ Opt-out response time ☐ Customer Service ☐ Other

Summary of Complaint: (use back of paper if necessary)

Click or tap here to enter text.

For internal use only

Submitted by: _____ Date submitted: _____

Date received by Privacy Officer: _____

Summary of Investigation and Resolution:

_____

_____

_____

_____

_____

Patient notification of resolution: Yes/No Date:_____Mechanism of notification: _____

_____ _____ _____

Privacy Officer Printed Name Privacy Officer Signature Date