EXHIBIT 8

Complaint Worksheet

Name (optional)________________________________ **Date of Birth (optional)**:____________________
Medical Record Number (optional) ____________________

Initiated by:________________________________ **Date**:____________________
Site:_______________________________________

Type:

- ☐ Access (time to get an appointment, response to telephone calls)
- ☐ Appeal (denial of services or payment by a health plan)
- ☐ Billing (refers to billing issues: billed for service, late submission)
- ☐ Communication (no call backs, not informed of abnormal tests)
- ☐ Housekeeping (dirty bathrooms, waiting rooms, etc.)
- ☐ Insurance (limited coverage, lack of specialists)
- ☐ Laboratory (off site, drawing techniques)
- ☐ Medical Care (not addressing medical questions)
- ☐ Medical Staff (issues with a particular provider: rude, hurried)
- ☐ Personnel (issues with staff: uncaring, rude)
- ☐ Pharmacy (medication issues – i.e. demanding pain medications)
- ☐ Policies (not willing to comply w/clinic policies, no show)
- ☐ Radiology (pertaining to radiology issues)
- ☐ Security/Safety (stealing, threats)
- ☐ Waiting Time (long wait, flow issues)

Comments:

Office Use Only:

0 Level 1 Level 1A Level 1B Level 2A Level 2B Level 2C Level 3 Level 3A

Disposition:

Date:

Approved 3/4/03 CCHN Physician Council

Submit to supervisor