

COMMUNITY CARE OF NORTH CAROLINA/CAROLINA ACCESS (CCNC/CA) COMPLAINT FORM INSTRUCTIONS

Medicaid and NC Health Choice recipients enrolled in the CCNC/CA managed care programs have a right to expect professional and appropriate medical care. You have the right to file a complaint if there are any concerns about your child's medical care, office staff courtesy, information about new medicine or special tests, or behavior you consider inappropriate, (including physical or sexual contact or provider alcohol/drug use).

INSTRUCTIONS FOR COMPLETING THE FRONT PAGE (1) OF THE FORM

We need to have some information about the complaint to begin an investigation:

1. On the first two lines, print your name, date you filled out this form, and if this complaint is for someone else, your relationship to that person.
2. Print the name and date of birth (DOB) of the person for whom you are filing the complaint. If you are making this complaint for yourself, give your name and DOB.
3. Please look on the Health Plan ID card of the person for whom you are making the complaint to complete the "Medicaid ID" field on the form:
 - **Medicaid:** Write the 10-digit Recipient ID number.
 - **Health Choice:** Write the ID number (begins with "YPP") printed below the child's Date of Birth.
4. Tell us where we can contact you by mail. If you have a P.O. Box use that address. .
5. Tell us the county where the patient who has the complaint lives.
6. If you have a telephone, please place the number here. If you do not have a telephone but there is a neighbor or relative phone number where we can leave a message, tell us that person's number and name. (We will not tell anyone why we are calling you and just leave a message asking you to call us.)
7. Print the name of the doctor or office staff person against whom you are making the complaint. If you know the name of the practice and it is different from your provider's name, also print the name of the practice on this line. You can also get this information from your Medicaid card, your doctor's appointment card or business card.
8. Tell us everything that about the reason for this complaint. It is helpful if you have names and the dates that the events occurred. If there is any other information or documents that give more information about the situation, please include a copy with this form.

INSTRUCTIONS FOR COMPLETING THE PAGE (2) OF THE FORM – DISCLOSURE NOTICE

Complete Section (1) to authorize us to use your name in the investigation.
Complete Section (2) to keep this complaint confidential.

It is helpful if we can use your name to open and research the complaint. However, if you prefer that your name remain private, your complaint will remain open only to match with similar complaints regarding the provider. It is important to understand that it is always more helpful when we are able to use your name as we investigate your complaint.

DMA will send you a confirmation letter within seven (7) days of receiving your complaint. Any actions or information resulting from complaint investigations must remain confidential. Therefore, DMA cannot inform you of any findings, decisions or actions taken with the provider or their staff because of your complaint.

Please call 1-888-245-0179 with any questions about the process or your specific complaint.
When all information is completed, mail this form and supporting documents as follows:

**DMA/Managed Care Section
2501 MAIL SERVICE CENTER
Raleigh, NC 27699-2501**

REMEMBER TO SIGN THE BACK OF THE FORM BEFORE MAILING!

