

Community Care Of North Carolina/Carolina ACCESS (CCNC/CA)

COMPLAINT FORM

CCNC/CA Quality Management (QM) staff reviews all complaints that come to our office. We take each complaint seriously and have a process in place for addressing them. It is not necessary to use your name when investigating a complaint. However, it is more effective to have your name when describing the concern to the provider. Therefore, we have included a place to sign your name on this form that will let us use your name when investigating your complaint. **Please do not sign both statements.**

1. If you agree to allow us to use your name in investigating this complaint, please sign the following:

I give the CCNC/CA QM staff permission to use my name when sharing my complaint with the Primary Care Provider (PCP) named in my complaint. The PCP has my permission to respond to the CCNC/CA QM staff concerning my complaint and release medical records regarding the patient when necessary.

Signature of Complainant

Date

Signature of Patient/Parent/Legal Guardian

Date of Birth

OR

2. If you would like your name to remain confidential and you do not want us to use your name in the investigation of this complaint, please sign below:

Signature of Complainant

Date

Signature of Patient/Parent/Legal Guardian

Date of Birth

If you have any questions regarding the use of this form or the CCNC/CA Complaint Process, please contact the Medicaid Managed Care office in Raleigh at 1-888-245-0179. *Thank you for giving us this opportunity to serve you better.*

Please Do Not Write Below This Line

CCNC/CA PCP Name: _____ CCNC/CA PCP#: _____

CCNC/CA Practice Name: _____

County Where CCNC/CA Practice is Located: _____

Comments:

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MA-3435 Figure 11b