

CAROLINA ACCESS COMPLAINT FORM INSTRUCTIONS

Carolina ACCESS wants you and other members of your family who are enrolled in Carolina ACCESS to have good medical care. If you think you have had problems obtaining appropriate and timely medical care, or feel that your primary care provider or office staff said and/or did something you consider inappropriate, (including physical or sexual contact or provider alcohol/drug use), please complete the attached Carolina ACCESS complaint form.

INSTRUCTIONS FOR COMPLETING THE FRONT PAGE OF THE FORM:

Before we can address your complaint, we need to have certain information that will tell us about your situation.

1. On the first two lines, print your name, the date you filled out this form, and if you are making this complaint for someone else, put your relationship to that person.
2. Print the name and date of birth (DOB) of the person on whose behalf this complaint is being made. (If you are making this complaint for yourself, put your name again)
3. Please look on your Medicaid card. Beside your name there is a Medicaid number (10 digits long); copy that number at "Medicaid ID". Put the name of the county in which you live.
4. Print your address or how we can contact you by mail. (If you have a P.O. Box, please put that number) Please enter the county where you live.
5. If you have a telephone, please place the number here. If you do not have a telephone but want to put someone else's number where we may reach you, please print that person's number and name. (We will not leave a message or discuss the purpose of the call with anyone other than you, but we may want to leave a message for you to call us.)
6. Print the name of the doctor or provider against whom you wish to make the complaint. If you know the name of the practice and it is different from your provider's name, print the name of the practice on this line. (You can also get this information from your Medicaid card)
7. Write in detail, what happened that caused you to want to make this complaint. It is helpful if you have people's names and the dates that the events occurred. If there is any other information or documents that can support the things you are saying, please include them when you send in this form.

INSTRUCTIONS FOR COMPLETING THE BACK PAGE OF THE FORM:

It is helpful in investigating your complaint if we have permission to use your name; however, if you don't want us to use your name, we will keep your complaint on file to see if we receive similar complaints before any investigation occurs. It is important for you to understand that it is always more effective when we are able to use your name as we investigate your complaint.

1. Gives us permission to use your name.
2. Tells us that you want us to keep your complaint on file, but you do not want us to use your name.
3. Please enter the name of the County where you live here: _____.

When all information is completed, mail this form to:

**ATTN: QM Nurse
DMA/Managed Care
2501 MAIL SERVICE CENTER
Raleigh, NC 27699-2516**

If you have any questions about the complaint process please call 1-888-245-0179

DMA will send you a receipt confirmation letter within 7 days of receiving your complaint. Results of complaint investigations must remain confidential; therefore, you will not be informed of findings or decisions regarding your complaint.