PATIENT CONCERNS AND GRIEVANCES FORM

Lumicera Health Services is dedicated to providing you with quality products and services. Please read your Patient Bill of Rights. In this document, we explain that you have the right to receive appropriate, professional and quality services. You also have the right to inform us of any concerns, grievances or complaints. You have the right to do so without being threatened or discriminated against.

If you are unhappy with our service, have a suspected medication issue or if you have concerns about safety or quality of care, we would like you to contact us. There are two ways for you to let us know about any grievances, complaints or concerns:

1. **Call us at 855-847-3553**
2. **Complete and mail this form to us**

We will either call you or send you a letter within five (5) calendar days of receiving your letter or phone call. We look into each of the concerns we receive. You will receive a letter within 14 calendar days letting you know how we will address your concern.

Please fax or mail completed form to: Lumicera Health Services
310 Integrity Drive
Madison, WI 53717
Fax: 855-847-3558

A grievance or complaint can also be filed with the complaint department of our accreditation organization ACHC at 855-937-2242.

Thank you for telling us about your concern. This will help us to improve the quality of our services.

Patient Information

Name _____ Date of birth _____

Description of the problem/concern/complaint (include dates, times and names, if possible)

_____

_____

_____

Other Information

Completed by _____ Date _____

Relationship to patient _____