ACHC ACCREDITED

Patient Concerns and Grievances

Gentry Health Services' staff strives to provide quality products/services consistent with our philosophy. As stated in your Bill of Rights and Responsibilities, you as the patient have the right to be given appropriate and professional quality care services without discrimination. You also have the right to voice your concerns, grievances, or complaints about your service without being threatened, restrained or discriminated against.

If you are unhappy with our service or have concerns about safety and/or the quality of care, please contact our Director of Pharmacy. You may either complete this form, call us at 1-844-443-6879 or visit our website at GentryHealthServices.com to submit your concerns.

Within 5 calendar days of receiving your concern, we will notify you by telephone, electronic mail, or fax that the matter is under investigation.

Within 14 calendar days, the organization will provide written notification to you with the results of its investigation and response.

- Mail form to: Gentry Health Services • 33381 Walker Rd., Suite A • Avon Lake, Ohio 44012

If you feel that Gentry Health Services has not properly resolved your concerns, you may contact the State Board of Pharmacy in your state (phone number will be provided if requested) , the Accreditation Commission for Health Care (ACHC) at 1-855-937-2242 or the Utilization Review Accreditation Commission (URAC) at 202-216-9010 during normal business hours for further assistance.

Patient Concerns & Grievances

Thank you in advance for bringing your concern to our attention. It will assist us in our continuing effort to improve the quality of our services.

Patient's Name: ____________________ **DOB:** ___/___/______

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

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Completed by (signature): ____________________ **Date:** ___/___/______

Relationship to patient (if applicable): ____________________

(For Office Use Only)

Patient's Address: ____________________

Patient's Telephone Number: (____)_____-______ **Patient's Medicare or Health Insurance Claim Number:** ____________________

Date Received: ___/___/______ **by:** ____________________

Follow-up by phone completed by: ____________________ **Date:** ___/___/______

Time: ________ AM / PM

Items discussed: ____________________

Resolution/ Action taken to resolve the complaint: ____________________

Follow-up letter completed by: ____________________ **Date completed:** ___/___/______
(please attach copy)

Date mailed: ___/___/______

Form completed by: ____________________ **Date:** ___/___/______