CLIENT FEED BACK FORM

(1) Account number:____________________________
Brithdate _____________________ Sex ___________

(2)Notification date: ________________(3) Clinic/facility:_______________________ (4) Department: _________________

(5) Even Date: _____________________ (6) Group: __________________Sub-group:_________ Member Type:__________

(7) Check appropriate Source Code, Comment type and Primary Category and associated Topic below it relating to the comment

Source Codes: □ Telephone □ In Person □ Suggestion

Comment Type: □ Concern □ Compliment/Recognition □ Suggestion

Categories: □ Facility □ Access □ Physician □ Operational Process □ Staff

Topics:

□ Co-pay Fees	□ Chart Availability	□ Ability to see Physician	□ Courtesy/Communication	□ Website usefulness
□ Coverage/Explanation	□ Damage/Lost articles	□ Appointment/Availability	□ Change PCP	□ Website usability
□ Eligibility	□ Delay Receiving Product	□ Appointment/Cancellation	□ Diagnosis-Delayed	□ Website information
□ Billing	□ Inadequate Facility	□ Appointment- Mix-up	□ Diagnosis-Missed/incorrect	□ Error
□ Concern/Appeals	□ Interpreters	□ Appointment-Referral/ Consult	□ Treatment-Delay After Diagnosis	□ Efficiency/Service
□ Received information	□ Parking			□ Other
□ Referral, Transfer, Authorization	□ Delay Returning Message/Rx	□ Appointment same day	□ Treatment-Inadequate/ inappropriate	
		□ Time with Provider		
□ Wait-Exam room	□ Wait-Service	□ Wait-Telephone	□ Wait-Waiting Room	

(8) Comments: ____
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(9) Customer Expectations:____
____
____

(10) Resolution: ____
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(11) Initiator: ____Telephone No. ______________________________

(12) SEND COMPLETED FORM FEEDBACK FORM TO P.O. Box 26882 Columbus Ohio 43226