CUSTOMER SERVICE FORM

Purpose: This form is to be used by Local Management Entity/ Managed Care Organization (LMEMCO) staff to document customer service issues such as concerns, complaints, compliments, investigations and requests for information involving any person requesting or receiving publicly funded MH/DD/SA services from a LME/MCO or a MH/DD/SAS provider.

		Tracking #:		
Person reporting customer service issue:			Date:	
Name:	Phone: H:	W:	C:	
Address:				
Person reporting customer service issue is:				
☐ Anonymous ☐ Attorney ☐ Consumer ☐ Consumer advocate/representative ☐ DMH/DD/SAS staff ☐ Family member ☐ Parent/Guardian ☐ DMA ☐ LME/MCO Staff ☐ Provider ☐ Other (specify):				
If customer service issue involves a client:				
Client name:	Phone: H:	W:	C:	
Address:				
DOB: Age: Gender:				
County of Services: Medicaid County: Home	LME/MCO:	Host LME/Me	CO:	
Race/Ethnicity: ☐ Hispanic/ Latino ☐ African Americ ☐ Native Hawaiian or Pacific Islander ☐ Multi-racial	can 🔲 Caucasian Unknown 🔲 Oth		☐ Asian	
Parent/Guardian:	Phone: H:	W:	C:	
Address:				
Funding Source(s): County Funds Health Choice	Medicaid	☐ Private Insurance ☐ S	tate Funds 🗌 Self-Pay	
Customer service issue was received via:				
☐ Call ☐ Customer Service Form ☐ Email ☐ ☐ DMA Quality of Care	Fax In Person	☐ Website ☐ Writt	en Correspondence	
If issue was referred to the LME/MCO, indicate referral source and specify which LME/MCO or office: Another LME/MCO County Office Provider's Office DMH/DD/SAS DMA DHSR Other (Specify):				
Type of Case: ☐ Complaint/Concern ☐ Compliment ☐	Information/Referral	Investigation Priority	: Routine High	
Nature of primary customer service issue. Issue is related ☐ Abuse, Neglect, Exploitation ☐ Basic Needs ☐ Access to Services ☐ Client Rights ☐ Administrative Issues ☐ Confidentiality/H ☐ Authorization/ Payment/Billing ☐ LME/MCO Function	IPAA ::	mary Issue) Provider Choice Quality of Care Service Coordination Betv Other (specify):	veen Providers	
Customer service issue notes: (Attach additional pages if	needed)			

Summary Of Issue(s), In	vestigation, and Actions Taken (Include dates) (Attach additio	nal pages if needed):	
Final Disposition: [Actio	n(s) taken include dates]		
Resolution			
<u>Issue(s) was(were)</u> :	☐ Resolved/Completed ☐ Partially Resolved ☐ Unresol	ved	
Resolved by:	☐ LME/MCO ☐ DHSR ☐ DMH/DD/SAS ☐ DSS ☐		
	☐ <u>Licensing Board</u> ☐ Pending		
Outcome of Complaints that were NOT Investigated:			
	☐ Information or technical assistance was provided to complai	nant	
	☐ Worked with Provider for Resolution		
	☐ Referred to Community Resource or Advocacy Group		
	☐ Referred to External Licensing or State Agency		
	☐ Referred to Another LME/MCO for resolution		
	☐ Mediation with parties		
Resolution was Appea	<u>led</u> :		
	□ N/A		
	2 nd Level Review to Client Rights Committee		
	2 nd Level Review to LME/MCO Director		
	Provider Appeal Panel		
Number of Calendar D	Days from Receipt to Completion:		
Number of Working D	ays from Receipt to Completion:		
Date Resolved:			
Written feedback of final disposition/resolution was provided to:			
Person completing this	torm:	Date:	