



1475 S. State College Blvd.  
Anaheim CA 92806

## MEDICARE BENEFICIARY COMPLAINT LOG

Date of receipt of complaint: \_\_\_\_\_

Patient's name: \_\_\_\_\_

Patient's address: \_\_\_\_\_  
\_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Patient's telephone number: \_\_\_\_\_

Patient's Medicare or Health Insurance Claim Number: \_\_\_\_\_

Description of complaint: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Action taken to resolve the complaint: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

Signature of representative

Date