KANSAS FOUNDATION FOR MEDICAL CARE, INC.

Medicare – Quality of Care Concerns Form

Print form; mail or fax completed form, and any additional summary pages, to the address or fax number at the bottom of the form.

STEP 1 – If you are a Medicare patient, and have concerns about the quality of healthcare you have received, please complete Section A below. If you are not the Medicare patient, but are filling out this form for the patient, please complete Sections A **and** B below:

Section A – Medicare Patient Information

Name _____ Medicare ID Number _____ Date of Birth _____

Address _____ Phone # _____

Section B – Contact Person Information

Name _____ Relationship to beneficiary: ☐ spouse ☐ relative ☐ friend ☐ other _____

Address _____ Phone # _____

STEP 2 – Healthcare provider information (for instance, name of involved hospital or physician):

Facility name (if applicable) _____ Physician name (if applicable): _____

Dates of service (admit and discharge dates): _____

STEP 3 – Please provide a brief summary of your concerns **(we will contact you within five days of receipt of this form to discuss your concerns, and make any clarifications before we start the review)**. Please attach another sheet if necessary.

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Signature: _____ Date: _____

Mail / fax completed form, and any additional summary pages, to:

Kansas Foundation for Medical Care, Inc.
2947 SW Wanamaker Dr.
Topeka, KS 66614-4193
Fax Number: 785-273-0237

Medicare Help Line: 1-800-432-0407

This material was prepared by the Kansas Foundation for Medical Care, Inc. (KFMC), the Medicare Quality Improvement Organization for Kansas, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. #8SOW-KS-BENE-06-04