# Complaint Form

Date Submitted: _____ Facility Representative: _____

Facility Name: _____ Facility Contact Number: _____

**Member/Patient's Name:**_____

**Medicaid Number:** _____

**Date of Appointment:** _____

**Appointment Time:** _____

**Who Transported Member/Patient:** _____

**Complaint Description:** _____

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FAX TO 877-601-0620

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***Logisticare Solutions, LLC Office Use ONLY***

Date Fax Received: _____ Date Fax Returned: _____
Date Complaint Entered:_____ Date Complaint Closed: _____
Entered By:_____
Complaint Number:_____