PrismHealth
NORTH TEXAS
PHARMACY

Client/Payer Complaint Form

Client Name/Name of Caller:	Company/Patient Involved:	
Address:		
City:	State:	Zip:
Phone Number:	Best Time To Contact (Circle One): Morning Afternoon Evening	
Email Address:		
Date of Complaint:	Employee(s) Involved:	
Description of Complaint: (Please continue on back, if needed)		

For Office Use Only:

Date Received:	Assigned To:
Resolution Description: (Please continue on back, if needed)	
Date of Resolution:	Date Patient Notified:
Further Action Required? YES NO	Signed: