



Complaint/Grievance Processing Form

Steps Ahead Maternity Care Plan

We wish to provide you with the best obstetrical care possible through the Medicaid Maternity Care Program and to help you resolve any problems you may experience. You have the right to file a complaint or grievance with your Care Coordinator at any time. The Care Coordinator will attempt to resolve your complaint. If you are not satisfied with the action taken by the Care Coordinator, your complaint will be forwarded to the Grievance Committee. The Committee will then review your complaint/grievance and let you know what action has been taken to resolve it.

Please complete the following information:

Part I: To be completed by the Beneficiary.

Name: (First, Last, MI)		Social Security #:	
Street Address:		City:	State: Zip:
Phone #:		DCHP:	
Please describe the complaint, problem, or grievance and how you would like it resolved:			

Beneficiary Signature Date Care Coordinator Date

Part II: To be completed by the Care Coordinator.

Action Taken:

Has the action resolved your complaint? Yes No

Beneficiary Signature Date Care Coordinator Signature Date

Action Taken by telephone signature not available

Date Sent to Steps Ahead: _____

**PLEASE SEND THIS COMPLETED FORM TO: Medicaid Maternity Care Program
PO Box 55947 BIRMINGHAM, AL 35255-5947 OR FAX TO 205-933-1235**