NEW MEXICO DEPARTMENT OF HEALTH

Division of Health Improvement
Program Operation's Bureau

CONSUMER COMPLAINT FORM

PROCEDURES FOR FILING A COMPLAINT AGAINST A FACILITY LICENSED BY THE DEPARTMENT OF HEALTH Program Operation's Bureau:

Please complete the complaint form in its entirety. Please detail your complaint allegations concisely, including information on the name, date of birth, and date of admit of the patient/resident/client involved. If the complaint allegations involved an incident with a staff member or department of the facility, please be sure to indicate the name of the staff person involved and their title (i.e. R.N., LPN, aide etc.), date that it occurred, and the name of the particular department that was involved (i.e. radiology, surgery, kitchen, dining room, etc.).

All complaint forms that are received by Complaint department are reviewed and a determination made as to the course of action. The Department must review the report and determine whether there are reasonable grounds for an investigation and if jurisdiction falls within our agency. Once the complaint report is reviewed, the complainant will receive a written notice of the Department's decision. If you have any additional questions, please feel free to contact us at **1-800-752-8649.**

Consumer Complaint Form

Complainant's Information	
Name of Person Filing Complaint:	**Relationship To Patient Whom Complaint Is About:**
Street Address or P.O. Box:	
City:	
State:	
Zip:	
Phone (day time):	**Cell:**
Facility Information	
Name of Facility Involved:	
Street Address of Facility:	
City and zip code:	

Name of Administrator:
If more than one facility was involved, please list additional facilities along with the address and city information:
Patient Whom Complaint is About
Patient's Full Name:
Patient's Date of Birth:
Details of the Event:
Admission Date of Patient
Discharge Date of Patient
Date(s)/Time(s) of Event
Location Where Event Occurred (i.e. unit, room, department, area, site):
Names of Staff Members Involved in Event:
Event Areas of Concern (check off here and describe in the next section): ☐ **Death** | ☐ **Abuse/Neglect** | ☐ **Restraints/Seclusion** | ☐ **Emergency Services** | ☐ **Exploitation** ☐ **Other**
Details of the event to include names, dates, titles of persons involved, areas of the facility, shifts, room numbers, etc (Give as much information as possible): PLEASE TYPE IF POSSIBLE, IF NOT PLEASE PRINT.

Did you report this event to anyone at the facility? Yes or No
If Yes, please provide the name & title of the person you reported this event to and the date it was reported:
If No, are you considering filing a complaint with the facility? Yes or No

If your complaint involves:	
Billing Issues involving private insurance:	**Please refer this complaint to your individual insurance representative as Department of Health Division of Health Improvement does not intervene in billing issues. You may also refer billing complaints to the Attorney General's Office-Consumer Protection Division 1-800-678-1508**
Physician Practices:	**Please refer your complaint to the New Mexico Medical Board, 2055 S. Pacheco Street Building 400 Santa Fe, NM 87505, 505-476-7220 or 1-800-945-5845 or** http://www.nmmb.state.nm.us/complaints.html

Please mail this form to:

New Mexico Department of Health
Division of Health Improvement/Program Operation's Bureau
Attn: Complaints Department
2040 S Pacheco Street, Second Floor, Suite 202
Santa Fe, NM 87505

You can also fax this form to 1-888-576-0012