

Big Sky Surgery Center, LLC Grievance Form

Patient Name: _____ Date of Service: _____

Date of Complaint: _____ Written Decision to: _____

Grievance: _____

Steps Taken to Investigate: _____

Result of Grievance Process: _____

ASC contact person _____

Date grievance process was completed (within 60 days) _____

Notification to Patient/Patient's Representative _____

Shared with the QAPI committee, MAC & Governing Body _____