SHIP/SMP Complaint Intake Form

3/23

Volunteer Information:

Name: **Phone Number:**

Beneficiary Information:

Name: **Medicare Number**:

Phone Number: **Date of Birth**:

Address:

City: **State**: **Zip**:

Plan Name:

State Where Beneficiary Enrolled:

Date of Incident:

Nature of the Complaint:

NOTE: Medicare Numbers and other beneficiary protected health information must not be transmitted via unsecure email. Send via encrypted email. If encrypting is not available send via postal mail or call your representative.

For Regional Representative:

Name: **Date Received:**

Is a CTM needed? No ____ Yes ____ Date CTM was submitted: _____