Part D Complaint Intake Form

CMS KCRO/Division of Medicare Operations

Complainant 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:

Information Received By:

Name: **Date:**

NOTE: DO NOT SEND THIS FORM VIA E-MAIL TO ENSURE CONFIDENTIALITY OF INDIVIDUAL'S PERSONAL INFORMATION IS PROTECTED.

Fax to: (443) 380-8887

NOTE: HICN/ Social Security Numbers and Other Beneficiary Protected Health Information must not be transmitted via e-mail