Please return this form to or call for assistance
請將本表格提交至以下地址或致電尋求協助
Go East Medical Services
Attention: Grievance Department
P.O. Box 3306
Daly City, CA 94015
grievances@gems-lv.org **
(702) 589-9686

PATIENT COMPLAINT/GRIEVANCE FORM
病人投訴/申訴表

PATIENT INFORMATION 病人資料

Date 日期: ________ / ______ / ________

Name:
姓名: ______________________________

GEMS MRN:
醫療卡號碼: ______________________________

Phone Number:
電話號碼: ______________________________

Best Time to Call:
最佳聯络時間: ______________________________

Language:
語言: ______________________________

Address:
地址: ______________________________

Email Address:
電郵地址: ______________________________

City:
城市: ______________________________

State:
州: ______________________________

Zip Code:
郵政編碼: ______________________________

Name and Relationship of Person Filing if Different from Above:
如填表人非上述投訴人，請註明填表人姓名及關係: ______________________________

INSURANCE INFORMATION 健康保險資料

☐ Self-Pay 自付
☐ Medicare 聯邦醫療保險計劃
☐ Medicaid 醫療補助計劃
☐ Private Insurance 私人保險
☐ Other 其他 ______________________________

DETAILS OF PROBLEM 問題詳細資料

Occurred Date:
發生日期: ______________________________

Location/Department:
地點 / 部門: ______________________________

Staff Name:
工作人員: ______________________________

Describe in Detail *(Add attachment if additional space is needed)*
請詳细說明（如有需要可加附件）

____
____
____
____
____

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PATIENT COMPLAINT/GRIEVANCE FORM
病人投訴/申訴表

PATIENT'S EXPECTATION OF RESOLUTION 病人期望的解決方案

Describe in Detail the Patient's Expectation of Resolution
請詳細寫出投訴人期望得到的解決方案

____
____
____

Signature of Patient or Legal Representative* 病人或合法代表簽名	Date 日期
Name of Legal Representative 合法代表姓名	Relationship of Legal Representative 合法代表與病人的關係
Signature of Witness (Required if patient is unable to sign) 見證人簽名（病人無法自行簽字時此項必填）	Date 日期

Note: Sending information over unencrypted email is not secure and increases risks that your information could be intercepted, viewed, copied, or shared by an unauthorized third party. By sending the grievance form to grievances@gems-lv.org unencrypted, I acknowledge that GEMS has warned me of the risks.

****注意：**使用未加密的電子郵件發送的信息並不安全，並且可能增加您的信息被未經授權的第三方截獲、讀取、複製、或分享的風險。 通過將申訴表以未加密的方式發送至 grievances@gems-lv.org，本人承認行健醫療中心已警示我相關風險。

Office Use Only:

Date Received by Clinic	Date Received by Grievance Department	Date Entered in Epic