CMA The Center For Memory and Aging
A Project of Pacific Center for Neurological Disease, Inc
PCND Neurosciences
pcndneuroscience researchinstitute
15644 Pomerado Road, Suite 401 Poway, California 92064 (858) 674-1289 Fax (858) 726-6221 pcndneurology.com

Appeal and Grievance Form

Use this form to file a grievance (complaint) related to your care at PCND Neurology.

Please type or print in dark ink.

Patient Information:

First Name:_____Last Name:_____Date of Birth:_____

Address:_____ City:_____

State:_____Zip:_____

Home phone :_____Cell phone:_____Email address:_____

What is the issue? _____
_____
_____
_____
_____
_____
_____

Check a box below to tell us what your issue or concern is about:

A medication (prescription drug) ☐

A medical service (medical care or equipment ☐

An issue not related to a specific medical service or medication ☐
Provide the details below:

_____
_____
_____

Service or Medication:

Have you already received the medical services or medication? YES NO
Service Date (MM/DD/YYYY) _____

Please tell us what happened. Be as specific as possible about what happened and who was involved. Include all dates of service and other related providers, pharmacies, labs or imaging facilities involved. You may attach extra pages if you need more space.

_____
_____
_____
_____
_____

What results do you want from us? (Please be specific and reasonable.)
Please tell us below:

_____
_____
_____

What additional documents have you attached?

Receipt(s) ☐
Medical bill(s) ☐
Medical records ☐
Letter from your provider(s) ☐
None ☐
Other: ☐

Signature:_____ Date:_____

Thank you for taking the time to complete this form. If we have more questions, we will contact you