Simple Inquiry Form

Composite Outcome/Activity Name: Simple Inquiries

Program: Issues and Inquiries **Last Date of Contact: _____**

Contact Location/Method (select one):
□ Email □ Phone □ In Person □ Fax □ U.S. Mail

Date of Contact (Month/Day/Year): _____
Date of Next Contact (Month/Day/Year): _____

Inquiry by (select one):
□ Beneficiary
□ Family Member
□ Caregiver
□ Program Partner/Subcontractor
□ Other Agency/Organization
□ Media
□ Health Care Provider

Issue:
□ Anonymous Complaint (Referral made)
□ Anonymous Complaint (No action)
□ Billings/Claims/Coverage Questions
□ Presentation
□ General Consumer Protection
□ Program Eligibility/Enrollment
□ Volunteer Inquiry
□ Resource Request
□ Non-SMP related info and referral
□ Other (specify)

County: _____

Program Involved (select one):
□Original Medicare Part A (hospital)
□Original Medicare Part B (outpatient)
□Medicare Advantage
□Medicare Part D (Rx Drugs)
□Medicare DME
□Medicaid
□Medigap
□Private Insurance
□Other Public Insurance
□Other (specify in notes)
□Home Health Care
□Long Term Care Facility
□Durable Medical Equipment (DME)
□Not Program Related
□Consumer Protection
□Medicare/Medicaid (General)

Was Simple Inquiry Resolved/Answered? □Yes □No **Time Spent:** _____

Notes: