



Patient Grievance Form

Date(s) of incident related to grievance: _____

Patient Name: _____ Date of Birth: _____

Patient Representative Name (If Applicable): _____

Nature of Grievance:

Resolution Requested:

Patient or Patient Representative Signature: _____

Date: _____

Please send form via email, mail or fax.

Attn: Compliance

118 Graceland Blvd. PMB 324

Columbus, OH 43214

Fax: (866) 397-1766

Email: compliance@offorhealth.com