

## CONSUMER CONCERN

DATE

CONTACT NAME

COMPANY

ADDRESS, CITY, STATE, ZIP

PHONE

EMAIL

IS THIS REGARDING A CLAIM?

YES

NO

CLAIM #

INSURED NAME

IS THIS A QUALITY OF CARE ISSUE?

YES

NO

*If YES, explain below and use additional pages if necessary*

Once completed, please email this form to the **MARQUEE QUALITY MANAGEMENT COMMITTEE:**

[QualityManagementCommittee@marqueemcs.com](mailto:QualityManagementCommittee@marqueemcs.com)

### DETAILS OF CONCERN

### DESIRED OUTCOME OF THIS CONCERN

#### FOR INTERNAL USE ONLY

DATE:

RECOMMENDATION:

FIRST SIGN OFF:

INITIAL:

SECOND SIGN OFF:

INITIAL: