NATIONAL HEALTH INSURANCE MANAGEMENT AUTHORITY

Complaints Form
Complete all Sections of this Form

Section A: Complainant Information

1. Complainant to fill where appropriate (part i, ii or iii)

NHIS Member/Beneficiary			
Name:			
NHIS Membership No.		NRC No.	/ /
Accredited Health Care Providers			
Name of Facility:		Accreditation No	
Other Stakeholder			
Name:			

2. Contact Details

Mobile No.		Date Complaint Reported	
Email:			
Physical Address			

Section B: Type of Complainant (Tick where applicable)

NHIS Principal Member		Accredited Health Care Provider	
Any other stakeholder (Please specify):			

Section C: Health Care Provider/NHIS Member/NHIMA staff/NHIMA etc. Complained Against

Health Care Provider		NHIS Member/beneficiary	

NHIMA staff		NHIMA	
Name :			
Location:			

Section D: Nature of Complaint

1	Shortages of medicines/Medical supplies		2	Hosp staff attitude		3	Waiting time	
4	Admissions		5	Double billing		6	Membership/registration	
7	Contributions		8	Claims Process				
9	Others (Specify)							

Section E: Details of the Complaint (Provide on another page if need be)

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Section F: Signature and Certification

Signature of Complainant:

Date of Complaint:

FOR OFFICIAL USE ONLY

Date Compliant Received		Complaint Serial Number	
Date Complaint Occurred		Date Escalated to Relevant Department	
Date Resolution Communicated to Member		Date File Closed/Transferred to Health Complaints Committee	

Resolution Log					
Member satisfied with Resolution?		Y		N	
If Yes, State Resolutions (at least 3)	Code	Resolution Description (Action Taken)			