

NIAGARA COUNTY DEPARTMENT OF HEALTH

MEDICAID COMPLAINT LOG

Reporter (if known) \_\_\_\_\_

Date \_\_\_\_\_

Received by \_\_\_\_\_

**COMPLAINT:**

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**DOCUMENTATION OF INVESTIGATION: (SIGNATURE AND DATE WITH ALL ENTRIES)**

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**STATEMENT OF RESOLUTION:**

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Signature \_\_\_\_\_

Date \_\_\_\_\_