Community Health Services

West Side Pediatrics * Fremont Family Practice * Birchard Medical Center

NO SHOW APPOINTMENT APPEAL FORM

Patient Name ______________________________ DOB _____________ Today's date _______________

Person completing form ____________________________________ Relationship ____________________

Are you appealing a **Dental** or **Medical** No-Show appointment? __________________

Physician or Dentist Name ____________________________ Length of time as a CHS patient __________

Date of No Show being appealed ________________ Notice: 1st ________ 2nd ________ 3rd __________

REASON(S) FOR APPEAL:

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CORRECTIVE ACTION PLAN: (What will you do differently if you are allowed to return as our patient?) Use back of form if necessary.

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Signature ____ Date ____________________

This form must be returned to CHS within 14 days from the postmarked date of your no-show letter. Forms received after that date will not be considered by the committee.

DO NOT WRITE BELOW THIS LINE TO BE COMPLETED BY THE NO SHOW COMMITTEE

Date Form Received ____________________ *Date Letter Sent:* _____________________

No Show Committee: Approved ________ Denied ________ Date ____________

Reason(s) for Denial:

Revised 9/07