Community Health Services
Your Partners for Better Health

NO SHOW APPOINTMENT APPEAL FORM

Today's date _____

Patient Name _____ DOB _____ Telephone _____

Address _____

Person completing form _____ Relationship _____

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

Date of No Show being appealed _____ Notice: 1st _____ 2nd _____ 3rd _____

REASON(S) FOR APPEAL:

_____

_____

_____

_____

_____

_____

CORRECTIVE ACTION PLAN: (How will you keep your appointments?) Use back of form if necessary.

_____

_____

_____

_____

_____

_____

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 PERFORMANCE IMPROVEMENT COMMITTEE

Date Form Received _____ *Date Letter Sent:* _____

No Show Committee: Approved _____ Denied _____ Date _____

Comments:

Revised 10/15