Community Health Services
Your Partners for Better Health

2221 Hayes Avenue • Fremont, Ohio 43420

NO SHOW APPOINTMENT APPEAL FORM

______/______/______
TODAY'S DATE

PATIENT NAME	DATE OF BIRTH ______/______/______	PHONE

ADDRESS – CITY, STATE & ZIP

PERSON COMPLETING FORM	RELATIONSHIP

Are you appealing a DENTAL or MEDICAL No-Show appointment? *(please circle which one)*

Date of No Show being appealed ______/______/______ Notice: ☐ 1st ☐ 2nd ☐ 3rd

REASON(S) FOR APPEAL

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CORRECTIVE ACTION PLAN – How will you keep your appointments? *(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 PERFORMANCE IMPROVEMENT COMMITTEE.

______/______/______
DATE FORM RECEIVED

______/______/______
DATE LETTER SENT

PI COMMITTEE: ☐ APPROVED ☐ DENIED

______/______/______
DATE

COMMENTS:
____
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