DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop MS C1-25-05
Baltimore, Maryland 21244-1850

[DATE] **Case ID:** [ID]

[NAME]
[ADDRESS 1]
[ADDRESS 2]

Dear [NAME]:

You deserve the highest quality care from your health plan. The Centers for Medicare & Medicaid Services (CMS) is the federal agency that administers the Medicare program. One of the ways we ensure quality care is to ask about the service you are currently receiving from your Medicare health plan and/or Prescription Drug Plan.

We are contacting you about a concern, question, or complaint made to 1-800-MEDICARE against [PLAN NAME] on [DATE]. The complaint was closed by the plan on [DATE]. We would like to know about your satisfaction with the outcome and handling of the complaint. We value your opinions, and your experiences are very important to us. This is your chance to help us serve you better. The information you provide will help improve the way Medicare plans handle complaints in the future. This is your opportunity to help us, and the health plan and/or Prescription Drug Plan, serve you better.

Your cooperation in filling out this brief 5-10 minute survey is greatly appreciated. All the information you provide is confidential and is protected by the Privacy Act. Your information will not be shared with anyone other than authorized persons at CMS and IMPAQ International, LLC, the independent contractor assisting with this survey. Your participation is voluntary and your decision to participate, or not to participate, will not affect your Medicare benefits in any way.

Instructions:
Please read the questions on the back of this page and mark each answer that best describes your opinion. For this survey, any concern, question, or complaint that you made to 1-800-MEDICARE is considered a complaint. If you filed the complaint on behalf of a Medicare beneficiary, please respond to Question 3 and Question 8 from the beneficiary's point of view and all other questions from your own perspective. After completing the survey, please place it in the postage-paid envelope provided with this letter and mail it to IMPAQ International, attn: "CMS Complaints Resolution Survey," c/o Tab Service Company, 310 S. Racine Ave., Ste 6S, Chicago, IL 60607.

If you have any questions about the survey or would like to complete the survey by phone, please call IMPAQ International toll-free at 866-677-4283 and ask for the CMS Complaints Resolution Survey, and please reference the Case ID number located above the date on this letter.

Q1. According to our records, the complaint you filed about [COMPLAINT CATEGORY] was recently closed by the plan. Was the complaint settled?

Yes No I Don't Know

Q2. Thinking about the aspects of the complaints process, regardless of whether you agree or disagree with the final outcome, please indicate how satisfied you are with each of the following:

	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied	I Don't Know/NA
Length of the complaint process from start to finish					
Courtesy of the plan representative					
Time your plan took to contact you					
Your understanding of the process to address complaints					
Explanation of the final outcome					

Q3. During the complaint process, did you (the Medicare beneficiary) experience any of the following? Mark a response for each line.

	Yes	No	I Don't Know/NA
Extreme stress, anxiety, or frustration			
Health complications			
Loss of health insurance coverage			
Need to use an out-of-plan provider			
Financial hardship			

Q4. Please briefly summarize the final outcome or decision regarding your complaint:

_____

_____

Q5. How satisfied are you with the final outcome of your complaint?

Very Satisfied Satisfied Dissatisfied Very Dissatisfied NA

Q6. Whether you agree or disagree with the final outcome, how would you rate your overall satisfaction with the way your complaint was handled by [Plan name]?

Very Satisfied Satisfied Dissatisfied Very Dissatisfied NA

Q7. Based on your recent experience, how satisfied are you with [Plan name]?

Very Satisfied Satisfied Dissatisfied Very Dissatisfied NA

Q8. How likely are you (the Medicare beneficiary) to stay with [Plan name]?

Very Likely Likely Unlikely Very Unlikely NA

Q9. Please confirm who is filling out the survey: The Medicare Beneficiary Someone Else

Q10. Do you have any suggestions or comments about how your plan could handle complaints better?

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