McLAREN FLINT

CUSTOMER SATISFACTION REIMBURSEMENT FORM
20/200 FORM

Patient Name: _____

Room Number: _____

Reporting Unit:_____

Employee: _____

Belongings Last Seen on Unit: _____

Description of Lost/Broken Item(s): (i.e. shoes, clothing, eyeglasses, etc.)

_____

_____

_____

_____

_____

Total estimated value of item(s) $_____

(If amount is greater than $200, send this form to Patient Experience 342-2994 for consideration.)

IN-PATIENTS

1) Nursing Office will provide cash reimbursement for up to $200.

2) Provide the Nursing Office with the completed form to obtain the cash.

3) Present the patient/customer with cash in the amount of $_____ .

4) Return this form with patient/customer signature to the Nursing Office.

Employee Signature: _____ Date: _____

Supervisor Signature:_____ Date: _____

Patient/Customer Signature: _____ Date: _____

The customer was: ☐ Satisfied ☐ Not Satisfied ☐ Unable to Determine

DISCHARGED PATIENTS:

1) Send completed form including the information below to Patient Relations.

2) A letter will be generated from Patient Relations.

3) A check will be processed from Accounts Payable within 10 days:

Patient Name: _____ Telephone: _____

Make Check Payable to: _____ Amount: _____

Address:_____

City_____ State_____ Zip Code _____