



Illinois Department of Insurance

Health Insurance Products Consumer Complaint Form

4800 Wabash Avenue
Springfield, IL 62711
Toll-free 877-527-9431 TDD:
866- 323-5321
FAX: 217-558-2083

<https://doi.illinois.gov/>

Revised 6/2026

Complaints filed with the Department are confidential and will not be released to any person or organization except the policyholder, insured or enrollee (or their authorized representative) who originated the complaint or the party against whom the complaint has been filed.

PATIENT INFORMATION

Last		First		MI	
Address		City		State	Zip
Date of Birth	Phone Number		Email		

INSURANCE INFORMATION

Insurance Company Name			Policy ID		
Policy Holder Name			Employer/Sponsor Name		
Claim Date(s) of Service			Claim Number(s)		
Type of Coverage	Health/PPO ☐	HMO ☐	Disability ☐	Long Term Care ☐	Medicare Supplement ☐
Other (please specify)					

COMPLAINT DETAILS

(Attach copies of any relevant correspondence)

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PATIENT AUTHORIZATION

I authorize the Illinois Department of Insurance to obtain financial and personal health information needed to conduct this investigation. I understand the information will be utilized solely for the purpose of conducting this investigation and may be viewed by an auditor of the Department of Insurance for quality review and examination of record purposes. I understand this information will be submitted to the entity the complaint is against, and the Department may share this information with other state agencies, federal and state law enforcement agencies.

I understand that my approval of this authorization is voluntary, and I may revoke it in writing at any time.

Signature of Complainant _____ Date _____

PLEASE READ:

Authorized representative information below is required if someone other than the patient, parent, or legal guardian is representing covered individual

Information related ONLY to this complaint will be shared with the below authorized representative

AUTHORIZED REPRESENTATIVE (If applicable)

Relationship to Patient

Last	First	MI
Address	City	State
Phone Number	Email	Zip
Organization Name (if applicable)		

Send completed form and any supporting documents to:

Illinois Department of Insurance
Office of Consumer Health Insurance
4800 Wabash Avenue
Springfield, IL 62711

FAX 217- 558-2083
EMAIL DOI.complaints@illinois.gov
File electronically at <http://insurance.illinois.gov>
Toll-free Consumer Hotline: 877-527-9431
TDD: 866-323-5321