



Illinois Department of Insurance

Health Insurance Products Provider Complaint Form

4800 Wabash Avenue
Springfield, IL 62711
877-527-9431 Toll-free
TDD: 866-323-5321
Fax: 217-558-2083
<https://idoi.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.

PROVIDER INFORMATION

Organization/Provider Name			
Attention		Date	
Address	City	State	Zip
Phone	Fax	Email	

PATIENT INFORMATION

Last	First	MI	
Address	City	State	Zip

INSURANCE INFORMATION

Insurance Company Name	Policy ID
Policy Holder Name	
Employer/Sponsor Name	Date Original Claim Submitted
Claim Date(s) of Service	Claim Number(s)
Type of Coverage Health/PPO ☐ HMO ☐ Disability ☐ Dental ☐	
Medicare Supplement ☐ Other	
If Other, please specify.	
Do you have a provider agreement with the insurance company or HMO (either directly or through a PPA, IPA or PHO)?	YES NO
Have you previously discussed this matter with the Department of Insurance Office of Consumer Health Insurance?	YES NO

IMPORTANT INFORMATION

For Prompt Pay Complaints: You must attach verification of claim submittal and documentation of your efforts to obtain payment such as written correspondence between you and the company. You must also attach a copy of the patient's health insurance ID card and a copy of the uniform bill as follows:

Hospitals and Institutional Claims – Current Hospital Services Claim Form

Physicians and all other providers – Current Physicians Services Claim Form

Dentists – Current Standard Dental Forms

For All Other Complaints: You must attach copies of correspondence between you and the company, a copy of the patient's health insurance ID card and a copy of the uniform bill as listed above.

NOTE: The release of identifiable health information may require written authorization from the patient

COMPLAINT DETAILS

(Attach copies of any additional documentation)

Provider Signature _____

Date _____

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
Submit on-line at <http://insurance.illinois.gov/>
Toll-free Consumer Hotline: 877-527-9431
TDD - 866-323-5321**