



# Illinois Department of Insurance

## Health Insurance Products Consumer Complaint Form

320 West Washington Street  
Springfield, IL 62767  
Toll-free 877-527-9431  
TDD: 866- 323-5321  
FAX: 217-558-2083

<http://insurance.illinois.gov>

Revised 3/2020

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)

--

## 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**

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

**Send completed form and any supporting documents to:**

**Illinois Department of Insurance  
Office of Consumer Health Insurance  
320 West Washington Street  
Springfield, IL 62767**

**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**