

Illinois Department of Insurance

Health Insurance Products Provider Complaint Form

320 West Washington Street Springfield, IL 62767 877-527-9431 Toll-free TDD: 866-323-5321 Fax: 217-558-2083 http://insurance.illinois.gov/

Revised 1/2020

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.

		PROVID	ER IN	FORN	ATION					
Organization/Provider Nam	ne									
Attention							Date			
Address			City				State	Zip		
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hone Fax					Email					
		PATIEN	NT INI	FORM	ATION					
Last			First					MI		
Address			C:4				64-4-	7:		
Address		INSURA	City NCIE II	NFOR	MATION		State	Zip		
			0.211							
Insurance Company Name					Policy ID					
						-				
Policy Holder Name										
Employer/Sponsor Name				Date Original Claim Submitted						
Claim Date(s) of Service				Claim N	Number(s)					
Claim Date(s) of Service					vuilibei (s)					
Type of Coverage Hea	alth/PPO	НМО			Disability		De	ntal		
Medicare Supplement	Othe	r								
If Other, please specify.						1				
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 discuss	ed this matter wit	h the Department o	f Insura	nce Offi	ce of Consumer					
Health Insurance?	YES				NO					
								-		
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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

	COMPLA	INT DEI	FAILS	
Attach	copies of any	additional	documer	ntation

Provider Signature

Date

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