



# Illinois Department of Insurance

## Workers Compensation Complaint Form

320 W. Washington Street  
Springfield, IL 62767  
**Phone** 866-445-5364  
**TDD** 217-524-4872  
**Fax** 217-558-2083  
DOI.Complaints@illinois.gov

**Has this complaint been filed before?** Yes  No  If so, please provide complaint # \_\_\_\_\_

Complainant/ Provider			Date		
Address		City		State	Zip Code
Phone Number(s)		Email Address			
Individual completing this form (if different from above)			Relationship to Complainant Self <input type="checkbox"/> Other _____		
Name of Insurance Company/ Third Party Administrator/ Agency my complaint is against					
Address		City		State	Zip
Patient					
Employer / Policyholder			Policy Number		
State policy was issued in		Date of Loss		Claim Number	
<b>This complaint involves</b> <input type="checkbox"/> Premium Billing or Audit <input type="checkbox"/> Class Code Dispute <input type="checkbox"/> Other <input type="checkbox"/> Cancellation <input type="checkbox"/> Non-renewal					
Original effective date of policy:			Date coverage did/will terminate:		
Is this a new or renewal policy?					
You may be entitled to a hearing to appeal the <b>cancellation</b> of your policy. <u>Please attach a copy of the notice you received from your insurance company with this complaint form.</u> Do you wish to request a hearing?    Yes <input type="checkbox"/> No <input type="checkbox"/>					
Please describe your complaint on the back and the following <b>must</b> be provided: <u>Required for all complaints:</u> <ol style="list-style-type: none"> <li>1. Completed Complaint Form</li> <li>2. Documentation of prior attempts to resolve the issue prior to filing complaint with this Department</li> </ol> <u>For Premium Billing/Audit/Other Disputes:</u> <ol style="list-style-type: none"> <li>1. Copy of Policy, Premium Audit Report, Billing Statements and/or Cancel/Nonrenewal Notice</li> <li>2. Documentation to support your dispute: previous audits and/or policy, Operations/Employee duties verification, NCCI determination, Certificate of Insurance, etc.</li> </ol> <u>For Provider Disputes:</u> <ol style="list-style-type: none"> <li>1. Documentation of nonpayment to the provider for either all or a portion of the bill: Copy of bill(s), medical data required to support bill.</li> <li>2. Documentation of delayed payment (payments made but not within 30 days) and if applicable, Company/TPA response refusal to pay interest.</li> <li>3. Documentation of bill(s)/claim previously disputed/denied and now determined to be compensable by settlement or IWCC Ruling. Copy of settlement or ruling.</li> </ol>					

**Important Notice:** Complaints filed with the Department of Insurance are confidential records and will not be released to any third parties, except the policy owner or authorized representative, or the party against whom the complaint has been filed.

