Illinois Department of Insurance

Health Insurance Products
Provider Complaint Form

Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001
877-527-9431 (toll free)
217-524-4872 (TDD)
http://insurance.illinois.gov

Updated - 12/11/2017

This form must be completed in its entirety. If any fields are not completed upon submission, it will be rejected

Provider Information

Organization/Doctor 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** ☐

Additional 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.

Please describe the procedure, treatment or drug that is being denied and why you disagree

REQUIRED

Patient Consent for External Review and Release of Medical Records

Patient, Parent of a Minor Child, or Legal Representative

(Legal Representative - guardian, power of attorney, executor or administrator - MUST attach official documentation).

By signing below I hereby authorize the release of medical records necessary for this review. I understand that these records may be obtained from the insurance carrier, the utilization review company, and/or any relevant medical provider(s) and will be utilized solely for the purpose of conducting this review and may be viewed by an auditor of the Department of Insurance for quality review and examination of record purposes.

Patient, Parent or Legal Representative Signature ONLY _____ **Date** _____

IF YOU ARE NOT THE PATIENT, PARENT OR LEGAL REPRESENTATIVE

Please complete the "Appointment of Authorized Representative" Form and submit with this request.

Return this request and supporting attachments to:

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Request
320 W. Washington Street
Springfield, IL. 62767

Fax Number - 217-558-2083
Message Center Website - https://mc.insurance.illinois.gov/messagecenter.nsf
Email - consumer_complaints@ins.state.il.us