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			
Last	**First**		**MI**
Address	**City**	**State**	**Zip**
Phone Number	**Email**		
Organization Name (if applicable)			

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

Submit Form