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.

PROVIDER INFORMATION

Organization/Provider 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**

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

COMPLAINT DETAILS

(Attach copies of any additional documentation)

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 http://insurance.illinois.gov/
Toll-free Consumer Hotline: 877-527-9431
TDD - 866-323-5321

Submit Form