Today's Date: _____

Maryland Insurance Administration

COMPLAINT FORM
Life and Health Insurance

Please use this form to submit a complaint about an insurance company

The Maryland Insurance Administration (MIA) is an independent State agency that regulates Maryland's insurance industry and protects consumers by ensuring that insurance companies and health plans act in accordance with insurance laws.

1. Your contact information

Name: _____ Relationship to insured/patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Insured/Patient Information (if different than above)

Name of insured: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

Are you authorized to act on behalf of the insured? ☐ Yes ☐ No

2. Insurance Information

Insurance Company: _____

Type of Insurance: ☐ Annuity ☐ Credit life/disability

☐ Dental ☐ Disability ☐ Health ☐ HMO ☐ Life ☐ Long Term Care ☐ Medicaid

☐ Medicare Supplement ☐ Medicare ☐ Other: _____

Type of policy: ☐ Group ☐ Individual ☐ Unknown

If group, name of group policyholder: _____

Policy or Member #: _____ Claim #: _____

Date Claim began: _____

How did you buy the policy? _____

Producer (Agent) name (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____

Please attach a copy of your insurance card or policy, if available.

3. Does this involve group insurance through your employer? ☐ **Yes** ☐ **No**

If so, Name of Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

4. Physician information

If your complaint is about a denied claim or pre-authorization for health care, please provide the name and contact information of the doctor who is treating you:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax Number: _____

5. Define your problem

Please check all that apply.

☐ Claim or preauthorization denial	☐ Unsatisfactory claim payment	☐ Billing problem
☐ Denial for medical necessity	☐ Cancellation/non-renewal of policy	☐ Refusal to insure
☐ Delays	☐ Misrepresentation or Agent handling	☐ Poor service
☐ Surrender problem	☐ Continuation of Health Insurance	☐ Mental Health/SUD parity

☐ Other: _____

6. Resolution

Give a brief explanation of the problem (use additional sheet if necessary): _____

If your complaint is about a health care claim or pre-authorization denial:

Have you appealed the denial? ☐ Yes ☐ No

Have you already received the care? ☐ Yes ☐ No

Is the health care urgently needed? If yes, explain why below. ☐ Yes ☐ No

6. Resolution

What do you want your insurance company to do? _____

_____

_____

_____

Are you sending support documents? ☐ Yes ☐ No

If yes, please **DO NOT** send original documents, copies only please.

NOTE: Please have the INSURED/PATIENT sign the attached "Release of Medical Information" as we may need to obtain medical records.

7. Submit documents

Once you have completed this form, please mail or fax it and all supporting documents, such as copies of letters or denials from the insurance company, medical records, or any other records you think are important to:

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
Fax: 410-468-2260 Or 410-468-2270 (for Medical Necessity Complaints)
Email: lhcomplaints.mia@maryland.gov

Questions?

Call our Insurance Consumer Hotline at

1-800-492-6116
Or
410-468-2244

Authorization for the Release of Medical Information

By signing this form, I either wish to file a complaint, or I authorize a health care provider to file a complaint on my behalf, with the Health Education and Advocacy Unit (HEAU) of the Office of the Attorney General and/or the Maryland Insurance Administration (MIA).

I authorize the HEAU and/or the MIA to contact my health care providers, my insurance carrier, HMO, and other State or Federal government agencies, to obtain any medical records, mental health or substance abuse records, and/or insurance information related to the complaint filed by me or on my behalf. I authorize my health care providers and insurance carriers to release any medical records, mental health or substance abuse records, and/or insurance information relevant to the complaint filed by me or on my behalf to the HEAU and/or the MIA. I understand that my treatment, payment, enrollment, or eligibility for benefits under my health plan may not be conditioned upon whether I sign this Authorization. However, I understand that the HEAU and MIA will be unable to process my complaint if I fail to sign this Authorization.

I authorize the HEAU and/or the MIA to release or redisclose my medical record and other information related to my complaint to my health care providers, my insurance carrier, HMO, and other State or Federal government agencies that may assist in the resolution of my complaint. I authorize the HEAU to assist me by mediating my complaint, filing a grievance or appeal with my insurance carrier, or by filing a complaint with the MIA or other State or Federal government agencies that may assist in the resolution of my complaint.

If my complaint is referred to or filed with MIA, I authorize MIA to release my medical records to health care providers, my insurance carrier, HMO, independent review organizations, medical experts and other government agencies or contractors that may assist in the resolution of my complaint.

There is the potential for information provided to be subject to redisclosure in the process of investigating the complaint and pursuing any action required as a result of the complaint investigation, in which case the information may no longer receive privacy protection under Federal law. I understand that information about my experience may be used to develop statistical information on the health care marketplace in Maryland or to examine the quality of care of an HMO, but the confidentiality of my identity and medical records will be protected in accordance with Maryland and Federal law.

This authorization is valid for one year. It shall be automatically revoked once the complaint has been resolved. I understand that I may revoke this Authorization at any time by notifying the Health Education and Advocacy Unit or the Maryland Insurance Administration, if my complaint has been referred to or filed with MIA, which will provide me with a form to sign confirming my revocation. A copy of the revocation will be provided to each party to whom this Authorization was provided. I understand that the revocation will not apply to the extent that a health care provider and/or insurance carrier has taken action in reliance on this authorization.

SIGNATURE(S) ON NEXT PAGE

_____ _____

Signature Date

_____

Relationship: If the person signing this release is not the patient, please give the relationship to the patient.

_____ _____

Patient Name Patient's Date of Birth

_____

Patient's Health Insurance Membership #

PLEASE NOTE: All patients 18 years of age and over must sign this consent form themselves, unless they have a legal guardian, personal representative, are incapacitated or have otherwise delegated authority to complete this form. If so, the signer must submit written proof of guardianship, representation, incapacity or other delegation of authority with this consent form. A parent or guardian must sign on behalf of an unemancipated minor, except in certain circumstances. Where Maryland law allows a person under 18 to consent to health care treatment without the consent of a parent or guardian, only the signature of the patient is necessary.