

healthcare@attorneygeneral.gov

www.attorneygeneral.gov



### Health Care Complaint Form

Health Care Section  
14<sup>th</sup> Floor, Strawberry Square  
Harrisburg, PA 17120

1-877-888-4877  
1-717-705-6938  
1-717-787-1190 (fax)

**Required fields are marked with an asterisk\***  
**Your information:**

|   |                    |  |           |         |
|---|--------------------|--|-----------|---------|
| Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Are you on active duty? <input type="checkbox"/> Yes <input type="checkbox"/> No |                    | Age Group:<br><input type="checkbox"/> Under 18 <input type="checkbox"/> 60-64<br><input type="checkbox"/> 18-34 <input type="checkbox"/> 65 and older<br><input type="checkbox"/> 35-59 |           |         |
| <input type="checkbox"/> Mr. <input type="checkbox"/> Ms.<br><input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.   | Name*              |  |           |         |
| Address*  |                    |  |           |         |
| City*   |                    | State*   | Zip Code* | County* |
| Daytime Phone Number*   | Home Phone Number* | Email Address  |           |         |
| (    )  | (    )             |  |           |         |

**If completing this form on behalf of someone else, please complete the following information:**

|   |                   |  |           |         |
|---|-------------------|--|-----------|---------|
| Are they a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Are they on active duty? <input type="checkbox"/> Yes <input type="checkbox"/> No |                   | Age Group:<br><input type="checkbox"/> Under 18 <input type="checkbox"/> 60-64<br><input type="checkbox"/> 18-34 <input type="checkbox"/> 65 and older<br><input type="checkbox"/> 35-59 |           |         |
| <input type="checkbox"/> Mr. <input type="checkbox"/> Ms.<br><input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.   | Name*             |  |           |         |
| Address*  |                   |  |           |         |
| City*   |                   | State*   | Zip Code* | County* |
| Daytime Phone Number  | Home Phone Number | Email Address  |           |         |
| (    )  | (    )            |  |           |         |

**Who is the complaint against?**

|                          |       |               |              |
|--------------------------|-------|---------------|--------------|
| Business Name*           |       | Phone Number: |              |
|                          |       | (    )        |              |
| Person to Whom You Spoke |       |               |              |
| Mailing Address          |       |               | Office/Suite |
| City                     | State | Zip Code      | County       |

**Insurance Information:**

|  |  |                         |                                      |
|--|--|-------------------------|--------------------------------------|
| Insurance Company  |  | Telephone #<br>(      ) |                                      |
| Mailing Address  |  |                         |                                      |
| City   |  | State                   | Zip Code                             |
| Subscriber's Name  |  | Policy No.              | Group No.                            |
| Patient's Name   |  | Patient's Date of Birth | Patient's Relationship to Subscriber |
| Type of Insurance: (Please check) <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Traditional Medicare<br><input type="checkbox"/> Medical Assistance <input type="checkbox"/> Other _____ |  |                         |                                      |
| Did you file a formal appeal (complaint/grievance with your health plan)? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, what was the outcome of the appeal?  |  |                         |                                      |

**Complaint Information:**

|  |   |                |
|--|---|----------------|
| Products or Services Purchased   | Date of Purchase/Transaction  | Purchase Price |
| Payment Method:<br><input type="checkbox"/> Cash<br><input type="checkbox"/> Check<br><input type="checkbox"/> Credit Card<br><input type="checkbox"/> Other<br>If other, enter other payment method:        | Are you requesting a refund?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, amount of refund requested?                                       |                |
| Has this matter been submitted to another agency?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, please provide name and address.  | Has this matter gone to collections?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, please provide name and address of the collection agency. |                |
| Is there or has there been a court action regarding this matter? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, please provide the court name, case number and the outcome of the case. |   |                |



**PLEASE READ CAREFULLY  
THE ATTORNEY GENERAL CANNOT ACT AS YOUR PRIVATE ATTORNEY**

The Attorney General cannot act as your private attorney. As a law enforcement agency, the primary function of the Office of Attorney General is to represent the public at large by enforcing laws including those prohibiting fraudulent, deceptive, confusing or misleading trade practices. Through the Health Care Section (HCS), the Attorney General does provide a service to consumers through this mediation unit, to resolve individual consumer complaints. The information you provide in this form will be used in an attempt to resolve your complaint and will be shared with the party(ies) against which the complaint is filed. Your complaint will remain on file with our Office and the information contained in it may be used to establish violations of Pennsylvania law.

**By signing below:**

1. I understand that filing a complaint with the HCS does not preserve my private right to sue, nor my appeal rights pursuant to Act 68, Medicare, or any insurance contract or policy.
2. I authorize the HCS to provide a copy of this complaint to any person or company about which I am complaining; and to any person or provider possessing medical and insurance records or information related to the complaint.
3. I authorize the HCS to transfer my complaint to another federal state, local, or other agency which may have jurisdiction over this matter. This authorization extends to any or all attachments which may be part of my case file, including any medical records the Office may obtain pursuant to my medical release.
4. By completing and submitting this complaint form, I authorize the Health Care Section to contact the party(ies) against which I have filed a complaint in an effort to reach an amicable resolution. I further authorize the party(ies) against which I have filed a complaint to communicate with and provide information related to my complaint to the Health Care Section. I verify that I have read and understand the informational sheet about this process and that the information provided is true and correct to the best of my knowledge, information and belief.

\_\_\_\_\_  
PRINT YOUR NAME

\_\_\_\_\_  
YOUR SIGNATURE

\_\_\_\_\_  
DATE

healthcare@attorneygeneral.gov

[www.attorneygeneral.gov](http://www.attorneygeneral.gov)



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### WHEN SHOULD YOU FILE A COMPLAINT?

If you are unable to resolve a health-related complaint directly with the person or company you are complaining against, **then** you should file a complaint with the Office of Attorney General, Health Care Section (HCS), by completing a complaint form and medical release authorization. If your complaint is against your insurance company, then you should refer to your contract to ensure that you have taken all the appropriate steps to file a complaint or grievance directly with the Plan. **Filing a complaint with the HCS does not preserve your appeal rights; therefore, you are encouraged to file an appeal with your insurance company while simultaneously filing a complaint with the HCS.**

The completed forms and any supporting documentation should be mailed to the address below, sent via email to [healthcare@attorneygeneral.gov](mailto:healthcare@attorneygeneral.gov) or you may file your complaint online at [www.attorneygeneral.gov](http://www.attorneygeneral.gov).

Office of Attorney General  
Health Care Section  
14<sup>th</sup> Floor, Strawberry Square  
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### HOW CAN YOU EXPEDITE THE PROCESSING OF YOUR COMPLAINT?

- Complete all portions of the complaint form that apply to your situation
- Describe what actions you have taken to resolve your complaint
- State what action you are seeking in order to resolve your complaint
- Include any supporting documentation that further explains your complaint and your position for resolving the complaint

### WHAT SHOULD YOU EXPECT AFTER YOU FILE A COMPLAINT?

Your complaint will be reviewed to determine if the HCS is the most appropriate agency to address your concerns. Upon receipt of your complaint, the HCS will send you an acknowledgment letter:

1. Providing your file number and assigned Agent; or
2. Advising that your complaint has been forwarded to another state or federal agency for handling.

If your complaint is assigned to an Agent, then **your Agent will forward a copy of your complaint (as submitted) to the person or company you are complaining against** and request a response to the complaint within 15 business days. Your Agent will forward you a copy of the response to your complaint and will keep you informed of any new developments in your case. Please allow your Agent a minimum of 30 days to contact you with an update on your file.

**KATHLEEN G. KANE**  
ATTORNEY GENERAL

healthcare@attorneygeneral.gov

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**Authorization to Release Medical and Insurance Records**

I hereby authorize any of the following: physician or medical practitioner; hospital or medical clinic or facility; insurance company; third party administrator; employer; debt collector; pharmacy; or other provider or person in possession of any of the medical and insurance records for

\_\_\_\_\_ to release the records and information, as described below, to:  
(patient's name printed)

Office of Attorney General  
Health Care Section  
Strawberry Square, 14<sup>th</sup> Floor  
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(717) 705-6938

These records should relate to the complaint I, or my authorized representative, filed with the Office of Attorney General. The purpose of this authorization is to aid the Health Care Section in the investigation of my complaint.

I authorize the Office of Attorney General, Health Care Section, to disclose any information obtained pursuant to this Authorization, along with the other information contained in its case file, to such other federal, state, local, or other agencies as deemed appropriate.

I understand that: (1) I have the right, upon written notification to the Office of Attorney General, to revoke this authorization. However, this authorization may not be revoked if the Attorney General's employees/agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization; (2) Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a covered entity may not condition treatment, payment, enrollment, or eligibility for benefits if I refuse to sign such authorization; and (3) information disclosed pursuant to this authorization is subject to re-disclosure by the Office of Attorney General and will no longer be protected by applicable federal and state privacy laws.

This authorization expires upon the conclusion of the investigation or enforcement action into the complaint by the Office of Attorney General.

Signature of Individual or Authorized Personal Representative \_\_\_\_\_

Description of Personal Representative's Authority \_\_\_\_\_

Patient's Social Security Number \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_

Date of Authorization \_\_\_\_\_

File No. \_\_\_\_\_  
(For office use only)

**KATHLEEN G. KANE**  
ATTORNEY GENERAL

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**Authorization to Release Medical and Insurance Records  
Related to Substance Abuse**

I hereby authorize the following:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
insurance records for \_\_\_\_\_  
records and information, as described below, to:

(physician or medical practitioner);  
(hospital or medical clinical facility);  
(insurance company); or  
(third party administrator) possessing medical and  
(patient's name printed) to release the

Office of Attorney General  
Health Care Section  
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These records should relate to substance abuse treatment as identified in the complaint I, or my authorized representative, filed with the Office of Attorney General. The purpose of this authorization is to aid the Health Care Section in the investigation of my complaint.

I authorize the Office of Attorney General, Health Care Section, to disclose any information obtained pursuant to this Authorization, along with the other information contained in its case file, to such other federal, state, local, or other agencies as deemed appropriate.

I understand that: (1) my substance abuse records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2), and cannot be disclosed without my written consent unless otherwise provided for in the regulations; (2) I have the right, upon written notification to the Office of Attorney General, to revoke this authorization, except to the extent that action has been taken in reliance upon it; (3) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a covered entity may not condition treatment, payment, enrollment, or eligibility for benefits if I refuse to sign such authorization; and (4) information disclosed pursuant to this authorization is subject to re-disclosure by the Office of Attorney General and will no longer be protected by applicable federal and state privacy laws.

This authorization expires upon the conclusion of the investigation into the complaint or enforcement action by the Office of Attorney General.

Signature of Individual or Authorized Personal Representative \_\_\_\_\_

Description of Personal Representative's Authority \_\_\_\_\_

Patient's Social Security Number \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_

Date of Authorization \_\_\_\_\_

File No. \_\_\_\_\_  
(For office use only)