COMMONWEALTH OF PENNSYLVANIA
OFFICE OF ATTORNEY GENERAL

DAVID W. SUNDAY, JR.
ATTORNEY GENERAL

Re: Health Care Complaint Form

Enclosed is a Health Care Section ("HCS") complaint form. Please clearly and legibly complete all portions of the complaint form that apply and provide all supporting documentation. You must sign the complaint form and the Authorization to Release Medical/Insurance Records and Information form and return them to move forward in the voluntary mediation process and allow us to process your complaint more efficiently.

Your complaint will be reviewed to determine if HCS is the most appropriate agency to address your concerns. If your complaint can be handled through the HCS voluntary mediation process, you will receive an acknowledgment letter identifying the agent handling your mediation file, who will also provide a copy of the complaint to the party you are complaining about and request a response.

If we cannot resolve your complaint during the voluntary mediation process, we have the authority, under Pennsylvania law, to bring a legal action in the name of the Commonwealth if we believe the facts, law, and public interest merit that action. In such a case, we would represent the interests of the Commonwealth as a whole, not you individually. Any lawsuit we may bring also may not address some or all of your particular issues and may not result in any recovery for you.

Please note that you may have the right to bring a private legal action. Be aware that for private actions, time may be of the essence because a statute of limitations applies. However, the Attorney General's Office cannot provide you with individual, private legal advice or representation. If your complaint is against your insurance company, filing a complaint with HCS does not preserve your appeal rights; therefore, you are encouraged to refer to your plan contract and file an appeal with your insurance company while simultaneously filing a complaint with HCS.

On behalf of the Office of Attorney General, thank you for bringing this matter to our attention. We hope to be of assistance in resolving your complaint.

Very truly yours,

Rebecca M. Zehring

Enclosure

Rebecca M. Zehring
Consumer Protection Agent Supervisor

Health Care Complaint Form

Health Care Section
14th Floor, Strawberry Square
Harrisburg, PA 17120

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

healthcare@attorneygeneral.gov
www.attorneygeneral.gov

☐ Please check if you or an immediate family member is a member of the military or a veteran.

☐ Please check if you are age 60 or older.

Your Information

Fields marked with (*) are required.

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

NAME* AGE

STREET ADDRESS*

CITY* STATE* ZIP CODE* COUNTY*

BEST PHONE NUMBER* EMAIL **By providing your email address, you agree to receive email communications from the Pennsylvania Office of Attorney General.**

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

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

NAME* RELATIONSHIP TO CONSUMER

STREET ADDRESS*

CITY* STATE* ZIP CODE* COUNTY*

BEST PHONE NUMBER* EMAIL **By providing your email address, you agree to receive email communications from the Pennsylvania Office of Attorney General.**

Insurance Information

INSURANCE COMPANY PHONE NUMBER

SUBSCRIBER'S NAME POLICY NO. GROUP NO.

PATIENT'S NAME DATE OF BIRTH RELATIONSHIP TO SUBSCRIBER

TYPE OF INSURANCE: (please check)

☐ HMO ☐ PPO ☐ POS ☐ TRADITIONAL MEDICARE ☐ MEDICAL ASSISTANCE ☐ OTHER

DID YOU FILE A FORMAL APPEAL (COMPLAINT/GRIEVANCE) WITH YOUR HEALTH PLAN?

☐ YES ☐ NO IF YES, PROVIDE THE OUTCOME OF THE APPEAL:

Who is the Complaint Against?

BUSINESS NAME*

PERSON TO WHOM YOU SPOKE | BUSINESS PHONE NUMBER

BUSINESS ADDRESS

CITY | STATE | ZIP CODE | COUNTY

PRODUCT OR SERVICE PURCHASED

DATE PURCHASED | **PURCHASE PRICE**

FORM OF PAYMENT:
☐CASH ☐CHECK ☐CREDIT CARD ☐OTHER- PLEASE PROVIDE METHOD

HAVE YOU CONTACTED OTHER AGENCIES? ☐ YES ☐NO

IF YES, PROVIDE NAME OF AGENCY AND CONTACT PERSON

HAS THIS MATTER GONE TO COLLECTIONS? ☐ YES ☐NO

IF YES, PROVIDE NAME AND ADDRESS OF THE COLLECTION AGENCY

IS THERE OR HAS THERE BEEN A COURT ACTION REGARDING THIS MATTER?
☐ YES ☐NO IF YES, PLEASE PROVIDE THE COURT NAME, CASE NUMBER AND THE OUTCOME OF THE CASE.

Please briefly explain your complaint.
Explain **WHAT** happened, **WHEN** it happened, and **WHERE** it happened. Describe the events in the order in which they happened. ATTACH COPIES of all applicable insurance contracts or policies, medical bills, explanations of benefits, correspondence, receipts, cancelled checks (front & back), advertisements or any other papers that relate to your complaint. Please complete and sign the attached "**Authorization to Release Medical/Insurance Records and Information**." PLEASE TYPE or PRINT your explanation. If additional space is needed, please use additional paper and attach to complaint form.

Filing a complaint with the Office of Attorney General does not preserve your appeal rights pursuant to your insurance contract or any applicable laws. To preserve your rights you must file an appeal (complaint or grievance) directly with your health insurer/administrator in conformance with the terms of your coverage.

WHAT SPECIFIC RESOLUTION ARE YOU SEEKING IN ORDER TO SETTLE YOUR COMPLAINT?

Optional Information

HOW DID YOU HEAR ABOUT US?

WHAT IS YOUR RACE OR ETHNICITY?

- ☐ HISPANIC/LATINO
- ☐ WHITE (NOT HISPANIC/LATINO)
- ☐ BLACK/AFRICANAMERICAN(NOTHISPANIC/LATINO)
- ☐ NATIVE HAWAIIAN/PACIFIC ISLANDER
- ☐ ASIAN
- ☐ NATIVE AMERICAN
- ☐ BIRACIAL
- ☐ OTHER

PLEASE READ CAREFULLY

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 subject to our document retention polices and applicable law 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 HCS does not preserve my private right to sue, or my appeal rights pursuant to Act 68, Medicare, or any insurance contract or policy.

2. I authorize 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 HCS to share my complaint with, or refer my complaint to, another federal, state, local, or other agency. This authorization extends to any or all information and attachments which may be part of my case file, including any medical records the Office obtains pursuant to my medical release.

4. By completing and submitting this complaint form, I authorize HCS 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 HCS. I verify that I have read and understand the information in this complaint form and any attached forms or correspondence, and that the information provided is true and correct to the best of my knowledge, information and belief.

PRINT YOUR NAME

YOUR SIGNATURE

DATE

Health Care Complaint Form

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14th Floor, Strawberry Square
Harrisburg, PA 17120

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healthcare@attorneygeneral.gov
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Authorization to Release Medical/Insurance Records and Information

THIS FORM HELPS US OBTAIN RECORDS OR OTHER INFORMATION NEEDED TO ADDRESS YOUR COMPLAINT. PLEASE COMPLETE, SIGN, AND RETURN AS SOON AS POSSIBLE.

Authorization Date: _____ Birth Date: _____ SSN (Last 4 Digits): _____

I, **(Print Name)** _____, hereby authorize the release of my insurance, financial, and medical records, and the disclosure of information from such records, to:

Office of Attorney General
Health Care Section
Strawberry Square, 14th Floor
Harrisburg, PA 17120
T: (717) 705-6938 F: (717) 787-1190
Email: healthcare@attorneygeneral.gov

Purpose of Authorization: Mediation, investigation, and/or enforcement action for consumer complaint.

Entities Covered by Authorization: Physician or medical practitioner; hospital or health clinic or facility; insurance company; third party administrator; employer; debt collector; pharmacy; and/or any other entity or person in possession of such records or information.

Expiration of Authorization: Conclusion of mediation, investigation, and/or enforcement action.

If applicable to your complaint, check below to release specific records or information:

- ☐ Alcohol/Drug Abuse Treatment/Referral
- ☐ Mental Health (Other than Psychotherapy Notes)
- ☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)
- ☐ Sexually Transmitted Diseases
- ☐ HIV/AIDS-related Diagnosis/Treatment

I also understand that: (1) I have the right to revoke this authorization in writing to HCS, except to the extent action has been taken relying on this authorization; (2) I have a right to a copy of this authorization; and (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 on signing such authorization.

I further authorize the Office of Attorney General to redisclose this information to other federal, state, local, or other agencies, or otherwise as necessary and permitted by law to take action on my complaint. I also understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, or otherwise prohibited by applicable law, may be subject to redisclosure, and may no longer be protected by the HIPAA Privacy Rule [45 CFR Part 164], the Privacy Act of 1974 [5 USC 552a], and/or other state, federal, or local law.

_____ _____
Signature of Individual/Authorized Representative *If representative, identify type/source of authority