stayinformed@attorneygeneral.gov

www.attorneygeneral.gov

UPMC/Highmark
Complaint Form

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

1-844-743-2015
1-717-705-6938
1-717-787-1190 (fax)

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 or sent via email to stayinformed@attorneygeneral.gov.

Office of Attorney General
Health Care Section
14th Floor, Strawberry Square
Harrisburg, PA 17120

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.

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Required fields are marked with an asterisk*

Your information:

Are you a veteran? ☐ Yes ☐ No Are you on active duty? ☐ Yes ☐ No			Age Group: ☐ Under 18 ☐ 60-64 ☐ 18-34 ☐ 65 and older ☐ 35-59	
☐ Mr. ☐ Ms. ☐ Mrs. ☐ 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? ☐ Yes ☐ No Are they on active duty? ☐ Yes ☐ No			Age Group: ☐ Under 18 ☐ 60-64 ☐ 18-34 ☐ 65 and older ☐ 35-59	
☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.	Name*			
Address*				
City*		State*	Zip Code*	County*
Daytime Phone Number ( )	Home Phone Number ( )	Email Address		

Who is the complaint against? ☐ UPMC ☐ Highmark ☐ Both

Insurance Information:

Insurance Company		
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) ☐ HMO ☐ PPO ☐ POS ☐ Traditional Medicare ☐ Medical Assistance ☐ Other _____		

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.

Please briefly explain your complaint. Tell **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."** PLEASE TYPE or PRINT your explanation. If additional space is needed, please use additional paper and attach to complaint form.

What specific resolution are you seeking in order to settle your complaint?

In order to fully evaluate your complaint, we will need you to answer the following questions. If you need more space, please attach additional pages.

1. Do you have Highmark Insurance?
   ___ Yes ___ No

2. Are you attempting to access a UPMC doctor(s)?
   ___ Yes ___ No

   a. If your answer was yes to question #2, please provide the following:
      i. Name of the doctor(s)_____
      _____
      _____
      ii. Name of the practice(s) including address(es) and phone number(s)
      _____
      _____
      _____
      _____
      iii. Reason why you are visiting this (these) doctor(s)
      _____

3. Are you trying to access a UPMC facility? ___ Yes ___ No
   a. If so, which facility? _____

4. Is the care you are seeking related to a prior or ongoing underlying medical condition?
   ___ Yes ___ No
   a. If so, what is the original condition? _____

5. Have you seen a UPMC doctor(s) in the past for this issue or a related issue?
   a. If so, when? _____
   b. Please provide the name(s) of the doctor(s) and the treatment you received.
      _____
      _____
      _____
      _____

6. Are you unable to locate a suitable doctor in your network or geographical area?
   ___ Yes ___ No

7. Are you being treated for cancer or any cancer related illnesses?
   ___ Yes ___ No

8. Have you recently been seen at a hospital in the Emergency Room?
   ___ Yes ___ No

   a. If yes to question #8, please list the name of the hospital and reason for your visit.
      _____
      _____

9. Are you pregnant or did you recently give birth?
   ___ Yes ___No

   a. If so, please provide the date of:
      i. Your confirmed pregnancy _____
      ii. Your delivery_____
   b. Are you experiencing any medical issues or difficulties related to the pregnancy/birth? If so, please provide a brief description of your problem.
      _____
      _____
      _____

10. Are you Medicare eligible? (Medicare eligible recipients are 65 years of age or older.)
    ___ Yes ___ No

11. Are you currently battling a serious or rare illness or do you require a special procedure or operation which can only be provided by a UPMC doctor or facility?
    ___ Yes ___ No
    If yes, please explain._____
    _____
    _____

12. Have you recently had a procedure at a UPMC facility and you feel the charges are too high?
    ___ Yes ___ No

    If so, please explain and provide only the most recent version of related bills, invoices and/or statements._____
    _____
    _____
    _____

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

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Authorization to Release Medical and Insurance Records

I hereby authorize any of the following: physician or medical practicitioner; 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, 14th 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)

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Authorization to Release Medical and Insurance Records Related to Substance Abuse

I hereby authorize the following:

_____ (physician or medical practitioner);
_____ (hospital or medical clinical facility);
_____ (insurance company); or
_____ (third party administrator) possessing medical and insurance records for _____ (patient's name printed) to release the records and information, as described below, to:

Office of Attorney General
Health Care Section
Strawberry Square, 14th Floor
Harrisburg, PA 17120
(717) 705-6938

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)