

# Ohio Department of Insurance

Ted Strickland – Governor  
Mary Jo Hudson – Director



## Provider Complaint

To register a complaint, please complete this form and submit to the Ohio Department of Insurance. Your complaint will be forwarded directly to the third-party payer. They should respond to you within 15 working days of receipt from our Department. Please do not send backup documentation with this form.

Ohio Department of Insurance  
Provider Complaint Unit  
50 W. Town St., 3<sup>rd</sup> Fl., Suite 300  
Columbus, Ohio 43215-1067

(614) 644-3428 or Fax (614) 644-3744

**FOR DEPARTMENT USE ONLY**

Ohio Department of Insurance  
Case # \_\_\_\_\_

If this involves Medicare, Medicaid, or self-insured plans (except Government, church, or school), please contact that governing agency. Please contact us directly for further information at the number listed above.

1. Are you a contracted provider with the third-party payer listed in this complaint?  
(If the answer to #1 is "No", skip questions #2 through 6)  Yes  No
2. Have you reviewed your contract?  Yes  No
3. Did you follow the third-party payer's internal grievance procedures?  Yes  No
4. Did you file a written appeal or written formal complaint with the third-party payer?  Yes  No
5. Enter date of original appeal. \_\_\_\_\_  
(Mo.) (Day) (Year)
6. Has Company responded to appeal?  Yes  No

If yes, please enter the date of the written response that was generated by the third-party payer's answer to your appeal/formal complaint.

\_\_\_\_\_  
(Mo.) (Day) (Year)

Please contact us at (614) 644-3428 if it has been 30 days and the Company has not responded to your appeal.

Provider name \_\_\_\_\_ Contact person \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Daytime phone # \_\_\_\_\_ Fax # \_\_\_\_\_  
 Email \_\_\_\_\_

Insured's name \_\_\_\_\_ Patient name \_\_\_\_\_  
 Insured policy or ID # \_\_\_\_\_ Group # \_\_\_\_\_  
 Name of third-party payer \_\_\_\_\_  
 Third-party payer contact person, phone, and address \_\_\_\_\_

Insurance Type:  Group  Individual  Dental  Vision  Govt. Programs  
 If group health, name of group/employer \_\_\_\_\_

**Claim Details:**

Claim number \_\_\_\_\_  
 Date of service \_\_\_\_\_  
 Total Billed \_\_\_\_\_  
 Date of submission \_\_\_\_\_  
 How submitted? Electronic  Paper

**Check type of problem: (Check all that apply)**

- Coordination of Benefits (COB) Issue
- Denial/Partial Denial of Claim (General Category)\*
- Incorrect Coding
- Overpayment Recovery
- Payment Delay/Prompt Pay Violation
- Timely Filing Limitations

\*Should a denial involve services which have been determined to be medically unnecessary or experimental/investigative and charges are in excess of \$500, the member/patient may have a right to file a formal appeal to the third-party payer requesting an external (independent) medical review of the case. Arrangements must be made directly with the third-party payer to facilitate this course of action. More information concerning the Patient Protection Act is available to members under "Consumer Services" at the Ohio Department of Insurance's web site, [www.ohioinsurance.gov](http://www.ohioinsurance.gov).

\*\*\*Attach an additional summary letter if you feel it is necessary to substantiate your complaint\*\*\*

**Other Comments:**

\_\_\_\_\_  
\_\_\_\_\_