Texas Department of Insurance

Physician / Provider Complaint Form

Texas Department of Insurance
PO Box 149091
Austin, Texas 78714-9091

Email: ConsumerProtection@tdi.state.tx.us
Main Number: (512) 463-6500 (800) 252-3439
Fax Number: (512) 475-1771

Notice

TDI uses information disclosed in this form to help resolve your complaint. Resolution may require TDI to share this information with the person or company named in your complaint. Although by law much of the information you submit may be considered public record, portions may be confidential. For example, you may include private information protected by the doctrine of common law privacy, medical records protected by the Medical Practice Act, or an e-mail address provided for the purpose of communicating electronically with TDI which is protected by the Texas Public Information Act. Sharing this information for purposes of processing your complaint does not waive these confidentiality protections. However, you may affirmatively consent to release of your e-mail address in response to a public information request or inquiry.

In addition, the Health Insurance Portability and Accountability Act (HIPAA) allow doctors and health care providers to provide information about a person's health care to health oversight agencies such as TDI. The law permits doctors and providers to disclose this information without authorization if the disclosure is for any purpose for which the agency is legally authorized to collect information.

If you would like more information about the public or confidential nature of information maintained by TDI, please consult our Open Records Policy and our Web Site Privacy Policy. This form is encrypted to meet privacy requirements.

Before Filing a Complaint

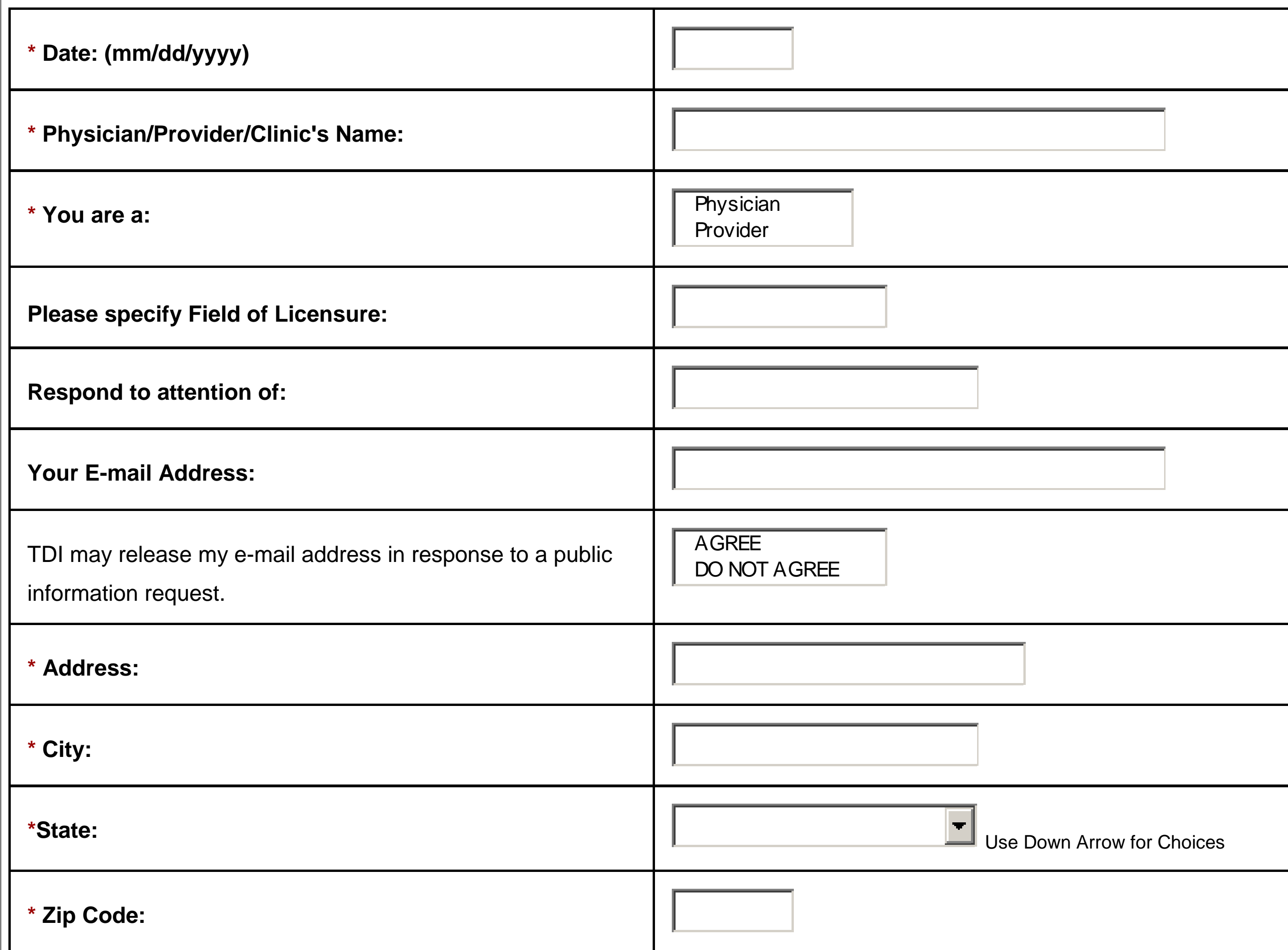
1. **Mail, Fax or Online?** - Print this on-line form (or the RTF/PDF version), fill in the information and mail to the address or fax to the telephone number above or complete and submit this online form.

2. **Supporting Documents?** - Complaints requiring supporting documents should be mailed or faxed. If you file on-line, print

to any supporting documents you mail or fax. Or, when you mail or fax supporting documentation, make a note on the top sheet that you have previously submitted an on-line form. This note will help us to identify your existing complaint file, reduce duplication, and assist you more quickly. You can expect an acknowledgement letter once your complaint form has been received.

3. One Form Per Claim? - Please submit one form for each claim.

4. Patient's Insurance Card? - Be sure to refer to the patient's insurance card information when filling out the complaint form or include a photocopy of the insurance card when you mail or fax supporting documents.



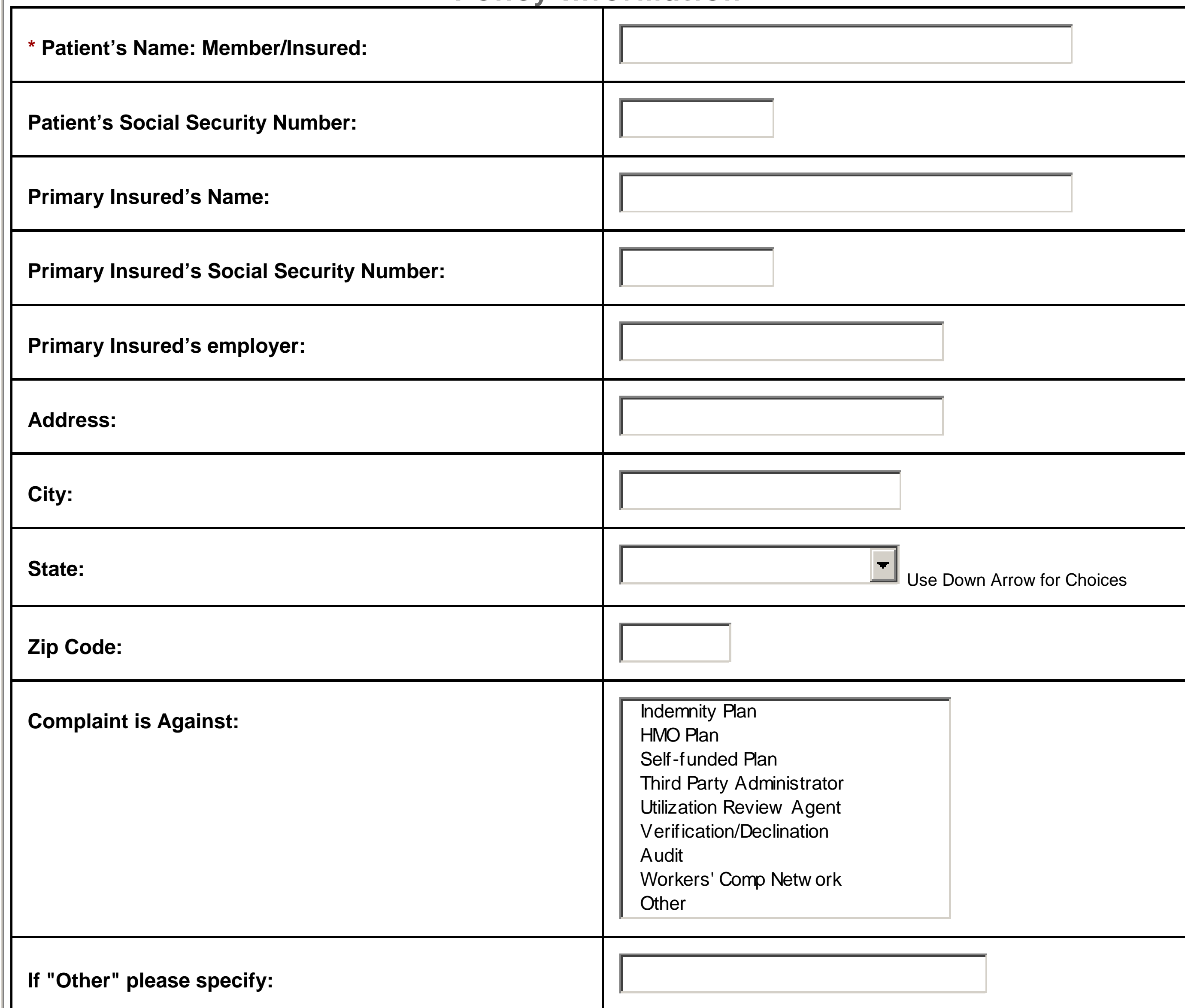
Physician/Provider Information

*** Required Field**

*** Date: (mm/dd/yyyy)**	
*** Physician/Provider/Clinic's Name:**	
*** You are a:**	Physician Provider
Please specify Field of Licensure:	
Respond to attention of:	
Your E-mail Address:	
TDI may release my e-mail address in response to a public information request.	AGREE DO NOT AGREE
*** Address:**	
*** City:**	
***State:**	Use Down Arrow for Choices
*** Zip Code:**	

Phone (Work)	Area Code [ ] - [ ] Extension [ ]
Fax:	Area Code [ ] - [ ]

Policy Information



* Patient's Name: Member/Insured:	
Patient's Social Security Number:	
Primary Insured's Name:	
Primary Insured's Social Security Number:	
Primary Insured's employer:	
Address:	
City:	
State:	Use Down Arrow for Choices
Zip Code:	
Complaint is Against:	Indemnity Plan HMO Plan Self-funded Plan Third Party Administrator Utilization Review Agent Verification/Declination Audit Workers' Comp Network Other
If "Other" please specify:	

Type of Coverage:	HMO Medicare Supplement PPO Workers' Compensation Other
If "Other" please specify:	
Date(s) of Treatment:	
* **For this claim, are you a contracted preferred provider with the member's insurance carrier?**	Yes No
If you are contracted with the member's insurance carrier, please type the name of the carrier in the next block:	**Insurance carrier Name:**
* **For this claim, are you contracted with the member's HMO plan?**	Yes No
If you are contracted with the member's HMO, please type the name of the HMO in the next block:	**Health plan Name:**
If you are contracted with the insurer or the HMO through an Independent Physicians Association (IPA), please type the name of the IPA in the next block:	**IPA Name:**
* **On what date (mm/dd/yyyy) did you, or your IPA if applicable, last renew, or enter into, your current contract with the insurer/HMO?**	
Are you a facility-based anesthesiologist, radiologist, or pathologist? If yes, select one:	Anesthesiologist Radiologist Pathologist

Patient Information

Please refer to the patient´s/insured´s health insurance ID Card for answers to the following questions or provide a copy of the member's health insurance card:

* Name of Patient´s/Insured´s HMO or Insurance Company	
* Member Number:	
* Group Name and Number:	
PCP´s Medical Group:	
Effective Date of Coverage (mm/dd/yyyy):	
Policy or Claim Number:	

Complaint Information

My Complaint involves: To make multiple selections, hold down the Ctrl key.	Audit Denial of Claims Incorrect Payment of Claims Medical Necessity Preauthorization/Precertification Prescriptions/Drug Formularies Provider Relations/Customer Service Referral Issues Slow Payment Verification/Declination Other
If "Other" please specify	
* Has the carrier acknowledged receipt of the claim(s)? If yes, please submit a copy of the acknowledgement.	Yes No
* Has the carrier denied receipt of the claim(s)? If yes, please submit a copy of the carrier’s letter denying receipt of the claim.	Yes No
* Has the carrier denied the claim(s) in writing? If yes, please submit a copy of the EOB.	Yes No

* **Has the carrier made any payment?**	Yes No
If the carrier has made any payment, please indicate amount paid [Example - 39.90]:	
* **Has the carrier requested additional information? If yes, please submit a copy of the request for additional information.**	Yes No
* **Did you provide services on referral from an HMO, PPO, or a preferred provider because the services were not reasonably available in-network?**	Yes No
* **Did you provide emergency care services?**	Yes No
Please describe your complaint.	

What do you consider to be a fair resolution to your problem?	

Before Clicking Submit

Complaints requiring supporting documents should be mailed or faxed. If you file on-line, print a copy of your completed complaint form before clicking the "Submit" button at the bottom of the form. Then attach that copy to any supporting documents you mail or fax. Or, when you mail or fax supporting documentation, make a note on the top sheet that you have previously submitted an on-line form. This note will help us to identify your existing complaint file, reduce duplication, and assist you more quickly. You can expect an acknowledgement letter once your complaint form has been received.

Provider Representative's Signature
Signature not required for those who submit the form online.

(Please print a copy of the completed complaint form for your records and for use when mailing in supporting documents.)

Access and Correction of Personal Information

With few exceptions, you are entitled to be informed about the information that the Texas Department of Insurance (TDI) collects about you. Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However, TDI may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that TDI correct information that TDI has about you that is incorrect. For more information about the procedure and costs for obtaining information from TDI or about the procedure for correcting information kept by TDI, please email the *Agency Counsel Section* of TDI´s Legal & Compliance Division or contact them by phone at (512) 475-1757 or review TDI's Corrections Procedures.

Texas Department of Insurance

Notice For Complaints Involving Claim Payments or Claim Delays

If you have a denial of claim or a slow claim payment issue, please attach each of the following items with your complaint:

- the HCFA 1500 or the UB-92
- evidence of claim submission
- evidence of prior collecting activities, including mail receipts and delivery confirmations
- specific details regarding telephone and written communications with the insurance carrier, including names, dates and telephone numbers, if possible.