File Complaint

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) allows 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.

A. Physicians/ health care providers and their representatives filing the complaint must complete Attachment A

I. Complainant Contact Information

Date (mm/dd/yyyy):

Name (First, Middle, Last):

Organization or Entity Name:

Street Address:

City or Town State/ZIP:

Insurance Company Name:

E-mail:

TDI may release my e-mail address in response to a public information request?

Please select
Yes (AGREE)
No (DO NOT AGREE)

Work Phone:

Work Phone Extension:

Home Phone:

Cell/Mobile:

Fax:

II. Insurance Policy Information

If the complainant is the policyholder, please go to III. Tell Us About Your Complaint.

Policyholder´s Name (First, Middle, Last):

Insurance Company Name:

Business Name:

Street Address:

City or Town State/ZIP:

III. Tell Us About Your Complaint

My complaint is against (Company and/or Person):

Type of Company and/or Person:

- Choose Type
- Do not know
- Adjuster
- Agent
- Attorney
- Broker
- Collection Agency
- Employer
- Engineer (Windstorm)
- Health Care Facility
- Health Care Provider
- Health Maintenance Organization (HMO)
- Independent Practice Association
- Independent Review Organization (IRO)
- Insurance Company
- Insured
- Medical Group
- Preferred Provider Organization
- Rental Car Agency
- Self-funded (ERISA) Plan
- Texas Department of Insurance
- Third Party Administrator (TPA) including Pharmacy Benefits Manager
- Title Company
- Utilization Review Agent (URA)
- Workers' Compensation
- Workers' Compensation Network - Certified
- Workers' Compensation Network - Informal/Voluntary
- Workers' Compensation - Designated Doctor
- Other

If Other, please describe:

Type of Coverage:

- Choose Type
- Do not know
- Accident
- Annuity
- Automobile
- Bond
- Commercial Lines
- Disability
- Flood
- General Liability
- Health
- HMO
- Homeowner
- Indemnity
- Life
- Medicare Supplement
- Occupation Accident
- PPO
- Title
- Windstorm
- Workers' Compensation (Claim)
- Workers' Compensation (Classification/Premium)
- Other

If Other, please describe:

Policy Number:

Policy Effective Date (mm/dd/yyyy):

Date of Loss or Service (mm/dd/yyyy):

Claim Number:

Title Insurance Only

Title File Number:

Title Closing Date (mm/dd/yyyy):

Workers´ Compensation Claim Only

DWC Claim Number:

Injured Employee´s Name (First, Middle, Last):

Date of Injury (mm/dd/yyyy):

HMOs or Group Health Only

Group Name:

Group Number:

Certificate Number:

Name of Employer:

Name of Adjuster:

Adjuster Work Phone:

Adjuster Fax Phone:

Adjuster Street Address:

City or Town State/ZIP:

Name of Agent:

Name of Agency:

Agent Work Phone:

Agent Fax Phone:

Agent Street Address:

City or Town State/ZIP:

IV. Your Complaint

Please describe your complaint:

V. Resolution

Describe what you would consider to be a fair resolution to your complaint:

VI. Submitting Your Complaint

If you **do not** have supporting documentation, you can file your complaint by:

- Mail:

  Texas Department of Insurance
  Consumer Protection (111-1A)
  P.O. Box 149091
  Austin, Texas 78714-9091

- Fax: **(512) 475-1771**
- Email: ConsumerProtection@tdi.state.tx.us

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Tips for submitting supporting documentation:

- Submit documentation within one day of filing your complaint.
- Types of documentation that will help us resolve most complaints includes:
- evidence that you paid for insurance (receipts, front and back copies of checks, billing statements, etc.)
- certificates or other documents showing you had insurance coverage (copy of your policy, binder, ID/enrollment card, declaration page, plan description, etc.)
- correspondence between you and your agent or insurance company (and/or any advertising) showing what you were told about your insurance coverage or your claims
- evidence of unpaid claims (copies of unpaid bills or evidence that you have paid bills for which you seek reimbursement, accident/claim reports, etc.)
- any other supporting documents that could help settle your complaint.
- 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
- explanation of benefits (EOBs)
- evidence of prior collecting activities and late payment, including mail receipts, copies of check stubs, and delivery confirmations (fax, postal, e-mail)
- specific details regarding telephone and written communications with the insurance carrier, including names, dates and telephone numbers, if possible.

For questions or assistance with filing a complaint, call:

Consumer Help Line: **1-800-252-3439**
Division of Workers´ Compensation **1-800-372-7713**

VII. Signature

Insured/claimant/representative signature

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A. Physicians/ health care providers and their representatives filing the complaint must complete Attachment A

VIII. 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 AgencyCounsel@tdi.state.tx.us of TDI´s Legal Services Division or review TDI´s Corrections Procedures.