

**Ohio Department of Insurance
Health Care Provider Complaint Form**

Please remember without proper documentation your complaint cannot be processed!

Provider Name: _____ Phone:() _____
Address: _____ Fax:() _____
City: _____ State: _____ Zip: _____ Contact Person: (Last) _____ (First) _____

Third Party Payer (TPP) (Full Name) : _____
Address: _____ Phone:() _____
City: _____ State: _____ Zip: _____ Fax:() _____
Contact Person Name: _____ (if known)

Insured Employer Name: _____
Insured Last Name: _____ **Insured First Name:** _____
Patient Last Name: _____ **Patient First Name:** _____
Insured Member/Certificate #: _____ **Policy #:** _____
Claim #: _____ **Group Plan #:** _____

Description of Claim and Verification of Untimely Payment

Date Services Rendered: _____	Amount of Claim: \$ _____ (actual amount billed to insurance)
Date Claim First Sent to TPP: _____	Sent by: <input type="checkbox"/> Mail <input type="checkbox"/> Electronic
Date Certified Letter Sent to TPP: _____	
Has TPP acknowledged receiving claim? ? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, How? _____ When? _____	
<hr style="border-top: 1px dashed black;"/>	
1. Do you have a contract with the TPP that contains a period of time in which the payer has to pay? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, What is it? _____	
2. Has the TPP made a timely payment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Has the TPP denied the claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Has the TPP requested additional information? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, What Information was Requested? _____ and When _____ attach separate page as necessary	
5. Have you had direct contact with any representative of the TPP regarding this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, provide the name, phone number & date(s) of contact. (attach additional page as necessary)	

<p><u>Please Mail this completed form AND documentation to:</u></p> <p>Prompt Pay Section Ohio Department of Insurance 2100 Stella Court Columbus, Ohio 43215-1067</p>	<p>I certify that the above information is correct:</p> <p>_____ Signature Date</p>
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NOTE: Documentation is incomplete with proof of claim submission.