



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., 3rd Fl., Suite 300
 Columbus, Ohio 43215-1067

email: MKD.Provider.Complaints@insurance.ohio.gov
 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? Yes No
 (If the answer to #1 is "No", skip questions #2 through 6)
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) 644-2577 if the Company has not responded to this complaint after 30 days.

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 Affairs" at the Ohio Department of Insurance's web site, www.insurance.ohio.gov.

Other Comments: _____
