Market Conduct Division
50 W. Town St., 3rd Floor
Suite 300
Columbus, OH 43215
(614) 644-2577
Fax (614) 644-3744
www.insurance.ohio.gov

Ohio Department of Insurance

Mike DeWine – Governor
Jillian Froment – 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., 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: _____

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