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Attorney General

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
CONSUMER PROTECTION DIVISION

WILLIAM D. GRUHN
Chief
Consumer Protection Division

Writer's Direct Dial No.

Dear Consumer,

Thank you for contacting the Health Education and Advocacy Unit regarding a complaint against a health care provider or insurer.

Enclosed please find a complaint form and a medical authorization for the release of medical and insurance information. To begin working on your complaint, we will need the following:

- ❑ Completed complaint form;
- ❑ Copies of bills and collection notices that you have received;
- ❑ Copies of all insurance documents and statements related to this complaint;
- ❑ Copies of all correspondence with any company, physician, hospital, insurer or other provider involved in this complaint; and
- ❑ Signed and dated Authorization for Release of Medical Information. (This form is necessary to allow us to obtain information related to your complaint and to release it as appropriate. For example, we may need to obtain records from your provider, release medical records to the insurance carrier, or we may need to refer your case to another agency.)

Failure to return a signed Medical Authorization form may result in closure of your case.

Please return the above-referenced materials by mail, fax, or email to:

Office of the Attorney General
Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
(410) 576-6571
HEAU@oag.state.md.us

Once we have received your materials your case will be assigned to a member of our staff on a first come, first served basis. You will be contacted by your assigned mediator or ombudsman once your case is assigned.

Please review the enclosed information explaining the complaint process and our procedures. If you have any questions or wish to check on the status of your complaint, please do not hesitate to contact us at (410) 528-1840 or toll free at (877) 261-8807. Our hotline is open Monday through Friday from 10:00 a.m. until 2:00 p.m.

Thank you,

Health Education and Advocacy Unit

What is the Health Education and Advocacy Unit (HEAU)?

The Health Education and Advocacy Unit of the Consumer Protection Division of the Attorney General's Office is a unit that handles consumer complaints involving a variety of issues in the healthcare marketplace. Typical complaints include medical billing and reimbursement problems, medical record access issues, medical equipment sales and warranty issues, and health insurance disputes. The Unit uses the process of mediation to attempt to resolve these consumer complaints. If you file a complaint that involves an issue that we cannot handle, we will attempt to refer your complaint to a more appropriate agency.

What is Mediation?

The process of mediation is one in which a third-party (mediator) works with parties in a dispute to try to bring about a cooperative settlement. We will gather information about your dispute and work toward a cooperative resolution of the problem.

Three keys to successful mediation are cooperation, information, and communication. For mediation to work, the parties to the dispute must be willing to try to resolve the problem. We find in most cases that businesses and consumers work hard to both avoid problems and to resolve problems when they arise. We will need information from both you and the business involved in the complaint.

The primary source of information from you will be the complaint form and the documents you provide about your complaint. We may call or write to you for additional information. It is important that you make clear in your complaint what you would like to see as a result of filing your complaint. We will also contact the businesses involved to seek information about the dispute and ask what offer the business would propose to resolve the problem. Most importantly, we will attempt to re-establish lines of communication between you and the business which will often lead to a resolution of the problem.

What are the Limits of Mediation?

If we are unable to resolve your complaint through mediation, there are other alternatives available to you. If your complaint is appropriate for arbitration, we may ask you and the business to agree to submit the issue to our office's binding arbitration program. You may wish to pursue the matter in Small Claims Court or with a private attorney. **THIS OFFICE CANNOT REPRESENT YOU IN COURT OR OTHERWISE ACT AS YOUR ATTORNEY.** If our mediation efforts are not successful, we will close your complaint file.

What if the Business Breaks the Law?

We regularly review complaints coming into our office and keep them on file for several years. If we find a pattern of complaints, the information is reviewed by Consumer Protection Division attorneys who will consider an enforcement action. Of the thousands of complaints we receive every year, a small percentage will involve issues which we pursue using our enforcement authority. Our attorneys act to enforce the law, but do not represent individual consumers in actions against businesses.

Is My Complaint Public Information?

We are required to make available some information from your complaint file upon request. However, to the extent that disclosure could reveal medical, psychological, or financial information, that information will not be released.

OFFICE OF THE ATTORNEY GENERAL

CONSUMER PROTECTION DIVISION

HEALTH EDUCATION AND ADVOCACY UNIT

200 Saint Paul Place, 16TH Floor
Baltimore, Maryland 21202-2021

Health Advocacy Hot Line

(410) 528-1840

Toll Free 1-877-261-8807

Fax (410) 576-6571

10:00 a.m. until 2:00 p.m.
Monday - Friday

Consumer Complaint Form

PATIENT INFORMATION: Please complete the following information regarding the PATIENT with the problem.

Patient's Name (Last, First, M.I.)	
Street Address	
City, State, Zip Code	
Daytime Telephone	
Evening Telephone	
Patient's Date of Birth	
E-Mail Address	

PERSON FILING COMPLAINT: Please complete the following information regarding the person filing the complaint.

Name (Last, First, M.I.)	
Street Address	
City, State, Zip Code	
Daytime Telephone	
Evening Telephone	
E-Mail Address	
Relationship to Patient	

HEALTH CARE PROVIDER INFORMATION: Please complete the following information regarding the health care provider or business involved in the complaint.

Name of Health Care Provider or Business	
Street Address	
City, State, Zip Code	
Telephone and Facsimile	
E-mail and/or Internet Address	
Person to Contact Regarding the Complaint	

INSURANCE INFORMATION: Please complete this section if your complaint involves an insurance company. (Copies of insurance cards are acceptable)

Primary Insurer	
Street Address	
City, State, Zip Code	
Telephone Number	
Policyholder	
Policy Number	
Effective Date	
Does this complaint concern a Marketplace/Exchange policy?	◯YES ◯NO ◯UNKNOWN
Is the policy through an employer?	◯YES ◯NO
Please include a copy of any correspondence you have received from your insurance carrier. ☞ **DO NOT SEND YOUR ORIGINALS**.	

****If other health care providers, businesses or insurers are involved in the complaint, please provide the same information as requested above for each additional health care provider/business/insurer.**

COMPLAINT INFORMATION

Please include a copy of the signed Authorization for the Release of Medical Information and copies of all bills, receipts, explanation of insurance benefits (EOBs), insurance card(s) and any other papers related to your complaint. Having copies of the relevant documents will allow us to assist you more quickly.

Have you received the service, care or product? _____

If so, when was the service, care or product received? _____

What type of product or service is involved in the dispute?

Please tell us about your problem.

How has the business responded to you? With whom did you speak?

What would you like the insurance carrier, provider or business to do to resolve your complaint?

Is there any additional information you would like to add?

Authorization for the Release of Medical Information

By signing this form, I either wish to file a complaint, or I authorize a health care provider to file a complaint on my behalf, with the Health Education and Advocacy Unit (HEAU) of the Office of the Attorney General and/or the Maryland Insurance Administration (MIA).

I authorize the HEAU and/or the MIA to contact my health care providers, my insurance carrier, HMO, and other State or Federal government agencies, to obtain any medical records, mental health or substance abuse records, and/or insurance information related to the complaint filed by me or on my behalf. I authorize my health care providers and insurance carriers to release any medical records, mental health or substance abuse records, and/or insurance information relevant to the complaint filed by me or on my behalf to the HEAU and/or the MIA. I understand that my treatment, payment, enrollment, or eligibility for benefits under my health plan may not be conditioned upon whether I sign this Authorization. However, I understand that the HEAU and MIA will be unable to process my complaint if I fail to sign this Authorization.

I authorize the HEAU and/or the MIA to release or redisclose my medical record and other information related to my complaint to my health care providers, my insurance carrier, HMO, and other State or Federal government agencies that may assist in the resolution of my complaint. I authorize the HEAU to assist me by mediating my complaint, filing a grievance or appeal with my insurance carrier, or by filing a complaint with the MIA or other State or Federal government agencies that may assist in the resolution of my complaint.

If my complaint is referred to or filed with MIA, I authorize MIA to release my medical records to health care providers, my insurance carrier, HMO, independent review organizations, medical experts and other government agencies or contractors that may assist in the resolution of my complaint.

There is the potential for information provided to be subject to redisclosure in the process of investigating the complaint and pursuing any action required as a result of the complaint investigation, in which case the information may no longer receive privacy protection under Federal law. I understand that information about my experience may be used to develop statistical information on the health care marketplace in Maryland or to examine the quality of care of an HMO, but the confidentiality of my identity and medical records will be protected in accordance with Maryland and Federal law.

This authorization is valid for one year. It shall be automatically revoked once the complaint has been resolved. I understand that I may revoke this Authorization at any time by notifying the Health Education and Advocacy Unit or the Maryland Insurance Administration, if my complaint has been referred to or filed with MIA, which will provide me with a form to sign confirming my revocation. A copy of the revocation will be provided to each party to whom this Authorization was provided. I understand that the revocation will not apply to the extent that a health care provider and/or insurance carrier has taken action in reliance on this authorization.

_____ _____

Signature Date

_____

Relationship: If the person signing this release is not the patient, please give the relationship to the patient.

_____ _____

Patient Name Patient's Date of Birth

_____

Patient's Health Insurance Membership #

PLEASE NOTE: All patients 18 years of age and over must sign this consent form themselves, unless they have a legal guardian, personal representative, are incapacitated or have otherwise delegated authority to complete this form. If so, the signer must submit written proof of guardianship, representation, incapacity or other delegation of authority with this consent form. A parent or guardian must sign on behalf of an unemancipated minor, except in certain circumstances. Where Maryland law allows a person under 18 to consent to health care treatment without the consent of a parent or guardian, only the signature of the patient is necessary.

Why can't I electronically sign the Authorization for Release of Medical Information?

We require a handwritten signature for privacy reasons. We apologize for the inconvenience, but the Authorization for Release of Medical Information form will need to be printed and signed and returned to us via mail, fax, or email. After signing, you scan and email the document using your cell phone. You can find instructions for your device online.

Print Form

Mail or FAX printed form to:
Office of the Attorney General
Consumer Protection Division
Health Education and Advocacy Unit
200 Saint Paul Place, 16TH Floor
Baltimore, Maryland 21202-2021

FAX 410-576-6571

Save Form

Attach the saved PDF to an email to:
HEAU@oag.state.md.us