OFFICE OF THE ATTORNEY GENERAL
CONSUMER PROTECTION DIVISION
HEALTH EDUCATION AND ADVOCACY UNIT
200 Saint Paul Place
Baltimore, Maryland 21202-2021

Health Advocacy Hot Line
(410) 528-1840
Toll Free 1-877-261-8807
Fax (410) 576-6571
9:00 A.M. until 4:30 P.M.
Monday - Friday

Provider Complaint Form

Patient Information

Please complete the following information regarding the Patient:

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

Insurance Information

Primary Insurer	
Policyholder	
Policy Number	

****If other insurers are involved in the complaint, please provide the same information as requested above.**

Physician or Health Care Provider Information

Name of Doctor or Business	
Street Address	
City, State, Zip Code	
Person to Contact Regarding the Complaint	
Contact Person's Telephone and Facsimile	
Contact Person's E-mail Address	

****If other doctors or business are involved in the complaint, provide the same information requested above.**

Heath Care Service Information

☞ Please attach a copy of the claim form your office submitted to the health insurance carrier, and a signed medical authorization form (if on file).

Has the Patient received the service or care?_____

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

Describe the problem with the health insurance carrier/HMO or other doctor or provider:

If the complaint involves a delay in medical treatment could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the member remaining seriously mentally ill with symptoms that cause the member to be in danger to self or others, please describe the medical treatment and the consequences of a delay:

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.