Mail To:
200 St. Paul Place, #2700
Baltimore, MD 21202

Today's Date: _____

MARYLAND INSURANCE ADMINISTRATION
LIFE & HEALTH APPEAL & GRIEVANCE COMPLAINT FORM

Do you have an existing complaint with the MIA?: _____ Yes _____ No
If YES: Investigator's Name: _____ MIA Complaint Number: _____

Complaint Information:
Name of Complainant: _____

Address: _____

City/State/Zip: _____

Email Address: _____

Phone: (H) _____ (W) _____ Fax: _____ Mobile: _____

Patient Information:
Name of Patient: _____

DOB: _____ Social Security # (optional): _____

Address: _____

City/State/Zip: _____

Email Address: _____

Phone: (H) _____ (W) _____ Fax: _____ Mobile: _____

Complainant's Relationship to Patient: _____

Insurance Information:
Insurance Company: _____

Policy Number: _____

Group Number: _____

Member Number: _____

If complaint involves mental health coverage, indicate the insurance company's mental health management company:
_____

Insurance Policyholder's Information
Policyholder Name: _____ Social Security # (optional): _____

Employer's Name: _____ Location of Employer (city/state): _____

Is the patient's insurance coverage through this employer?: _____ Yes _____ No

Indicate is Policyholder is a: _____ Federal Employee _____ State Employee _____ County Employee _____ Municipality Employee
_____ Full-Time Military _____ Self Employed _____ Other

Indicate if coverage is through: Medicare _____ Yes _____ No
Medicare HMO _____ Yes _____ No

If YES, is the primary payer?: Medicare _____ Yes _____ No
Medicare HMO _____ Yes _____ No

Is the patient in an HMO?: _____ Yes _____ No

Treating Physician's Information

Name of Physician: _____

Address: _____

City/State/Zip: _____

Telephone: (W) _____ Fax: _____

Please provide details of your complaint and give us as many names and dates as possible. (Please send copies of any documentation you have which would assist us in investigating your complaint, such as denial notices, medical records and any denial letters from the insurance company). Please indicate whether you believe the situation to be urgent.

Have you appealed the Insurance Carrier's decision? _____ Yes _____ No

What was the outcome?

The Medical Release form, below, should be signed by the patient or the authorized party, if the patient is a minor or has a legal guardian. Also, please enclose a copy of your insurance card(s).

Authorization for the Release of Medical Information to the Maryland Insurance Administration

By signing this form, I either wish to file a complain, or I authorize a health care provider to file a complaint on my behalf with the Maryland Insurance Administration (MIA).

I authorize 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 the MIA to release my medical record and other information related to my complaint to me 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 MIA to assist me by filing a complain with other State or Federal government agencies that may assist in the resolution of my complaint.

If my complaint is referred to or filed with HEAU by the MIA, I authorized HEAU 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 complain investigation.

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 Maryland Insurance Administration, which will provide me with a form to sign confirming my revocation.

_____ _____

Signature Date

_____

Relationship: if the person signing this release is not the patient

_____ _____

Patient Name Patient DOB

_____

Patient's Health Insurance Membership Number

PLEASE NOTE: *All patients 18 years of age and over must sign this consent form themselves, unless they have a legal guardian, personal representative or are incapacitated. If so, the signer must submit written proof of guardianship, representation or incapacity 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 of guardian, only the signature of the patient is necessary.*