

SUPERINTENDENT OF INSURANCE
John G. Franchini 505-827-4299



DEPUTY SUPERINTENDENT
Robert Doucette 505-827-5832

NEW MEXICO | OFFICE OF
SUPERINTENDENT
OF INSURANCE

INSURANCE HEALTH CARE PROVIDER COMPLAINT FORM

The New Mexico Office of Superintendent of Insurance investigates health care provider complaints filed against health care insurers such as health maintenance organizations, individual health plans, group and blanket plans, provider service networks, non-profit healthcare plans and third-party payers or their agents that provide, offer or administer health benefit plans subject to the insurance laws and regulations of this state. The Superintendent can assist with grievances regarding provider termination, discrimination, credentialing, timely payment of claims and other provider concerns in regards to the operations of the health insurer or plan.

Provider Information			
Name (First, Middle Initial, Last)			Title
NPI	Email Address		Phone
Practice/Group Name (If applicable)			
Address		City	State Zip Code
Authorized Contact Name		Email Address Phone	

Insurance Company Information			
Name		Contracted: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Address		City	State Zip Code
Type of Plan: HMO <input type="checkbox"/> PPO <input type="checkbox"/> EPO <input type="checkbox"/> POS <input type="checkbox"/> Other <input type="checkbox"/>			

Complaint Type (Please check all that apply):					
Credentialing			Plan Operations		
Request Date	Response Date	Contract Date	Eligibility <input type="checkbox"/>	Termination <input type="checkbox"/>	
			Prior Authorization <input type="checkbox"/>	Payment of Claims <input type="checkbox"/>	
			Discrimination <input type="checkbox"/>	Other <input type="checkbox"/>	
Have you already contacted the Insurance Company with this issue?					Yes <input type="checkbox"/> No <input type="checkbox"/>
Is this complaint related to any previously submitted complaints?					Yes <input type="checkbox"/> No <input type="checkbox"/>

Main Phone: 505-827-4601
Main Fax: 505-827-4734
Toll Free: 1-855-4-ASK-OSI

Mailing Address:
P.O. Box 1689
Santa Fe, NM 87504-1689

Physical Address:
1120 Paseo de Peralta
Santa Fe, NM 87501

Website: WWW.OSI.STATE.NM.US

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Please describe your complaint, the attempts you have made to resolve the complaint, and the outcome you are requesting: (Attach additional pages, if necessary)

(This area contains horizontal lines for text entry.)

Copies of any correspondence between you and the Company, Uniform Bill and Customer Authorization Form (if applicable), are required.

Provider Signature: _____ Date: _____

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Please complete this page if your complaint involves a denial or delay in obtaining prior authorization or a delay or denial of payment for a claim.

PATIENT AUTHORIZATION FORM

Claim Information			
Patient Name		Employer Name	Group #
Policy ID Number	Claim Number	Date of Service	Date of Claim Submitted
Date prior authorization requested and procedure or referral:			
Insurance Company Name			
Insurance Company Address			

Note: The release of individually identifiable health information requires written authorization from the patient.

I _____ (Patient Name), authorize _____ (Insurance Company Name) to release all medical records, including nonpublic personal health information and nonpublic personal financial information, which are related to this complaint, to the Office of Superintendent of Insurance. I authorize the release of such information, as necessary for the investigation, evaluation and resolution of my complaint, as allowed by law and on a need-to-know basis. I understand that my health insurer protects such information from unauthorized disclosure under federal and state law and other Office of Superintendent of Insurance rules and regulations. I understand that the Office of Superintendent of Insurance does not act as an attorney for private citizens.

Patient's Signature _____ Date _____

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BATCH COMPLAINTS

Insurance Company Information							
Name				Contracted		Yes	No
Address			City		State	Zip Code	
Type of Plan:	Individual	Group	HMO	PPO	EPO	POS	Other
Have you already contacted the Insurance Company with this issue?						Yes	No
Is this complaint related to any previously submitted complaints?						Yes	No
Claim Information							
Patient Name				Employer Name		Group #	
Policy ID Number		Claim Number		Date of Service		Date of Claim Submitted	
Insurance Company Name							
Insurance Company Address							
Claim Information							
Patient Name				Employer Name		Group #	
Policy ID Number		Claim Number		Date of Service		Date of Claim Submitted	
Insurance Company Name							
Insurance Company Address							
Claim Information							
Patient Name				Employer Name		Group #	
Policy ID Number		Claim Number		Date of Service		Date of Claim Submitted	
Insurance Company Name							
Insurance Company Address							
Claim Information							
Patient Name				Employer Name		Group #	
Policy ID Number		Claim Number		Date of Service		Date of Claim Submitted	
Insurance Company Name							
Insurance Company Address							
Insurance Company Information							

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Insurance Company Information			
Name		Name	Name
Address		Address	Address
Type of Plan :			
Have you already contacted the Insurance Company with this issue?			
Is this complaint related to any previously submitted complaints?			
Claim Information			
Patient Name		EmployerName	Group #
Claim Number			
Policy ID Number			
Insurance Company Name			
Insurance Company Address			
Insurance Company Information			
Claim Information			
Patient Name		EmployerName	Group #
Claim Number			
Policy ID Number			
Insurance Company Name			
Insurance Company Address			
Insurance Company Information			
Claim Information			
Patient Name		EmployerName	Group #
Claim Number			
Policy ID Number			
Insurance Company Name			
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Claim Information			
Patient Name		EmployerName	Group #
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Insurance Company Information							
Name				Contracted		Yes	No
Address			City		State	Zip Code	
Type of Plan:	Individual	Group	HMO	PPO	EPO	POS	Other
Have you already contacted the Insurance Company with this issue?						Yes	No
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Claim Information							
Patient Name				Employer Name		Group #	
Policy ID Number		Claim Number		Date of Service		Date of Claim Submitted	
Insurance Company Name							
Insurance Company Address							
Claim Information							
Patient Name				Employer Name		Group #	
Policy ID Number		Claim Number		Date of Service		Date of Claim Submitted	
Insurance Company Name							
Insurance Company Address							
Insurance Company Information							
Claim Information							
Patient Name				Employer Name		Group #	
Policy ID Number		Claim Number		Date of Service		Date of Claim Submitted	
Insurance Company Name							
Insurance Company Address							
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Claim Information							
Patient Name				Employer Name		Group #	
Policy ID Number		Claim Number		Date of Service		Date of Claim Submitted	
Insurance Company Name							
Insurance Company Address							
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