ATTORNEY GENERAL Letitia James

COMPLAINT FORM

State of New York
Office of the Attorney General
HEALTH CARE BUREAU
The Capitol
Albany, NY 12224-0341
Tel. (518) 776-2477 Fax (518) 650-9365

Consumer Helpline
1-800-428-9071

For the Hearing Impaired
TDD 1-800-788-9898

http://www.ag.ny.gov

1. Please TYPE or PRINT clearly in DARK ink.
2. Make sure to enclose COPIES of important papers concerning this complaint.

CONSUMER Information

Name	Home Telephone #
Street Address	Work Telephone #
City/Town County State Zip Code	

COMPLAINT Information

Name of person or company you are complaining about:

Address

City/Town State Zip

Telephone #

Date(s) of Service	Cost of Service $	How paid (check those that apply)	Name/Relation of Patient (if other than self):
		○ Cash ○ Check ○ Credit Card ○ Other	

Name of Your Health Plan and Your Identification Number: ID number for family member (if complaint involves family member):

Type of Health Plan
○ HMO ○ Preferred Provider Organization (PPO) ○ Point of Service plan (HMO-POS) ○ Indemnity
○ Medicare (traditional) ○ Medicare + Choice (HMO) ○ Medicaid ○ Medicaid HMO
○ Other _____ ○ No insurance ○ Don't Know

Do you have insurance through your employer? ○ Yes ○ No
If yes, what is the name of your employer?

Date you complained to the individual or company:

By: ○ Mail ○ Telephone ○ in person Person Contacted: Job title:

Did you file a formal appeal or grievance with your health plan?

What was the response to the complaint or appeal?

Has the matter been submitted to another agency or attorney? [If yes, please provide name and address]
○ Yes ○ No

Has this matter gone to collections? [If yes, please provide name and address of collection agency]
○ Yes ○ No

Please describe the complaint on the reverse side.

Briefly describe your complaint (please attach extra pages if necessary):

Did someone refer you to this office?
○ Yes ○ No If so, who?

Read the following before signing below.

PLEASE attach **PHOTOCOPIES** of your **HEALTH PLAN IDENTIFICATION CARD** (both sides), as well as any relevant documents, such as the Explanation of Benefits (EOB) from your health plan, denials of service, bills, correspondence, relevant sections of your subscriber contract or member handbook, etc. **DO NOT SEND ORIGINALS**

☞ **NOTE: In order to resolve your complaint we may send a copy of this form to the individual or company about whom you are complaining.**

In filing this complaint, I understand that the Attorney General is not my private attorney, but represents the public. I also understand that if I have any questions concerning my legal rights or responsibilities, I should contact a private attorney. I have no objection to the contents of this complaint being forwarded to the individual or company the complaint is directed towards, or to another agency if my complaint is referred to that agency. The above complaint is true and accurate to the best of my knowledge.

I also understand that any false statements made in this complaint are punishable as a Class A Misdemeanor under § 175.30 and/or § 210.34 of the Penal Law.

Signature _____ Date: _____

➜ Remember to enclose COPIES of any documentation with regard to this complaint.

➜ Mail to: NYS Office of the Attorney General
Health Care Bureau
The Capitol
Albany, NY 12224-0341