DCI Missouri Department of Commerce & Insurance

Provider Credentialing Complaint

MAIL TO
Missouri DCI
PO Box 690
Jefferson City, MO 65102
800-726-7390 / 573-751-2640
Fax 573-526-4898
RelayMO TTY Dial 711 or
1-800-735-2966

Please complete all information and enclose copies of correspondence, screen shots or other documentation that will help us understand your complaint. Send this form and attachments to the above address.

PLEASE PRINT, TYPE OR WRITE CLEARLY IN BLACK OR BLUE INK

1 PROVIDER INFO

PROVIDER NAME _____ PHONE _____ TAX ID NO. _____

ADDRESS _____ _____ ____ _____ _____
STREET CITY STATE ZIP CODE COUNTY

EMAIL _____ CONTACT PERSON _____

PRACTITIONER TYPE. Please select which applies to you:

☐ Physician ☐ Physician assistant ☐ Pharmacist ☐ Podiatrist ☐ Chiropractor ☐ Optometrist

☐ Dentist ☐ Psychologist ☐ Licensed clinical social worker ☐ Advance practice nurse ☐ Other _____

2 COMPANY INFO

HEALTH CARRIER NAME (INSURANCE COMPANY or HMO) _____

DATE CREDENTIALING APPLICATION WAS SENT TO HEALTH CARRIER

_____ _____ ____ _____ _____
STREET CITY STATE ZIP CODE MM/DD/YYYY

ADDRESS WHERE CREDENTIALING FORM WAS MAILED — LEAVE BLANK IF FILED ELECTRONICALLY:

_____ _____ ____ _____
STREET CITY STATE ZIP CODE

HOW APPLICATION WAS SENT

☐ Electronically
☐ Fax or mail

3 REASON FOR COMPLAINT

The law recognizes the following potential violations:

☐ No notice of receipt of credentialing application ☐ Notice of receipt of credentialing application not timely

☐ No access to provider Web portal ☐ Decision to approve or deny not made timely ☐ Other _____

4 DOCUMENTATION & SIGNATURE

Attach copies of any documentation that will help identify the health plan that has allegedly violated the state credentialing law, and the nature of the alleged violation, such as cover letters, screen shots if the credentialing form was filed electronically, or correspondence.

SIGNATURE _____ DATE (MM/DD/YYYY) _____