Print Reset

DIFP
Department of Insurance, Financial Institutions & Professional Registration

Provider Complaint Report

MAIL TO
Missouri DIFP
PO Box 690
Jefferson City, MO 65102
800-726-7390
573-751-2640
TDD: 573-526-4536

My complaint is against: ☐ Insurance company ☐ Third party administrator (TPA)

Please complete all information and enclose copies of correspondence and other papers that will help us investigate your complaint. Sign and date on back side at bottom. **Note:** A copy of this form and any of the enclosed information will be sent to the party you are complaining about. Send form and attachments to the above address.

PLEASE PRINT, TYPE OR WRITE CLEARLY IN BLACK OR BLUE INK **1 PATIENT ONLY PER COMPLAINT FORM**

1 PROVIDER INFO

PROVIDER NAME _____ **PHONE** _____ **TAX ID NO.** _____

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

EMAIL _____ **CONTACT PERSON** _____

2 INSURED INFO

INSURED NAME _____ **IF GROUP POLICY:** _____ _____
EMPLOYER NAME POLICY HOLDER NAME

ADDRESS _____ _____ _____ _____
If known STREET CITY STATE ZIP CODE

3 INFO ON COMPANY/THIRD PARTY ADMINISTRATOR THAT COMPLAINT IS ABOUT

COMPANY/ TPA NAME _____

ADDRESS _____ _____ _____ _____
STREET CITY STATE ZIP CODE

4 POLICY INFORMATION

_____ _____
GROUP **or** POLICY NUMBER ISSUE DATE

_____ _____
ID **or** CERTIFICATE NUMBER ISSUE DATE

_____ _____ _____
CLAIM NUMBER DATE OF CLAIM SERVICE DATE

5 TYPE OF COVERAGE (Check one)

☐ Individual health
☐ Group health
☐ Med supplement
☐ Other _____

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6 REASON FOR COMPLAINT (Check one)

☐ Claim denial ☐ Prompt pay ☐ Pre-authorization ☐ Payment amount ☐ Recoupment ☐ Other _____

7 DETAILS OF COMPLAINT (Attach separate sheet if needed)

8 DOCUMENTATION & SIGNATURE

DOCUMENTATION NEEDED:

- Copy of patient's ID card
- Evidence of claim submission
- Copy of correspondence with company

Signature of complainant or authorized representative _____ DATE _____