DCI Provider Complaint Report

Missouri Department of Commerce & Insurance

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

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

Please complete all information and enclose copies of correspondence and other papers that will help usinvestigate 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 _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

EMAIL _____ PHONE _____

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

_____
NAME OF COMPANY OR INDIVIDUAL YOU ARE COMPLAINING ABOUT

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

4 POLICY INFORMATION

_____ GROUP or POLICY NUMBER _____ ISSUE DATE

_____ ID or CERTIFICATE NUMBER _____ ISSUE DATE

_____ CLAIM NUMBER _____ DATE OF LOSS

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 _____