



Missouri Department of Commerce & Insurance

DCI

Provider Complaint Report

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 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 _____
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