HEALTH CARE BUREAU CONSUMER COMPLAINT
State of Arkansas

Office of the Attorney General
Health Care Bureau
323 Center Street, Suite 200
Little Rock, AR 72201

Contact Information
(501) 682-2341
1-800-482-8982 (in AR)
(501) 682-6073 TDD #

Your Information

☐Mr. ☐Mrs. ☐Ms.

_____
Your Name

_____
Mailing Address

_____
City State Zip Code

_____ _____
Daytime Phone No. Evening Phone No.

_____ _____
E-Mail Address (Optional) Date of Birth

Patient's Information (if different)

☐Mr. ☐Mrs. ☐Ms.

_____
Patient's Name

_____
Mailing Address

_____
City State Zip Code

_____ _____
Daytime Phone No. Evening Phone No.

_____ _____
E-Mail Address (Optional) Date of Birth

Your Complaint is Against (Respondent) (Provide as much information as possible)

Name: _____Contact Person: _____ Phone: _____

Street Address:_____City/Town:_____State:_____Zip:_____

Account No.:_____ Date of Service:_____

Have you complained to the company/individual? ☐Yes ☐No

Person Contacted: _____ Job Title: _____ Phone No.:_____

Nature of response: _____ _____

_____

_____

Date of response: _____

Is court action pending? ☐Yes ☐No

Primary Insurance Information (If applicable to your Complaint)

Insurance Name: _____Contact Name:_____Phone No.: _____

Address:_____City/Town:_____State:____ Zip:_____

Type of Plan : ☐HMO ☐PPO ☐Dental ☐Medicare ☐Supplemental ☐Other _____

Employer Name:_____ Phone No.:_____ Self Insured? ☐Yes ☐No

Employer Address: _____City/Town:_____ State:____ Zip:_____

Policy Holder: _____ Group: _____ ID#:_____

A Description of Your (or the Patient's) Complaint. (Please use additional paper, if necessary. Also, attach copies of all documents related to your Complaint). PLEASE DO NOT SEND ORIGINALS.

_____

_____

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_____

Type of Resolution/Relief You Are Seeking

_____

_____

_____

_____

☐ Check here if you only want to notify our office of your concerns and do not want us to contact the other party or initiate a resolution process.

AUTHORIZATION TO RELEASE MEDICAL/INSURANCE RECORDS

Please read and submit the following medical/insurance release authorization. Entry of your name below is required in order to process your complaint.

I, (enter name) _____, hereby authorize any of the following: physician or medical practitioner, hospital or medical clinic or facility, insurance company, third party administrator, employer, debt collector, pharmacy, or other provider or person possessing any medical and insurance records for (enter name of individual/patient)_____, to release the records and information, as described below, to:

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These records should relate to the complaint I, or my authorized representative, filed with the Office of the Attorney General. The purpose of this authorization is to aid the Health Care Bureau (HCB) in the investigation of my complaint.

I authorize the HCB to release my medical record and other information related to my complaint to my health care providers, my insurance carrier, HMO, and other State or Federal government agencies that may assist in the resolution of my complaint.

If my complaint is referred to, or filed with, the Arkansas Insurance Department (AID), I authorize the AID to release my medical records to health care providers, my insurance carrier, HMO, independent review organizations, medical experts and other government agencies or contractors that may assist in the resolution of my complaint.

I understand that: (1) I have the right, upon written notification to the Office of the Attorney General, to revoke this authorization; (2) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a covered entity may not condition treatment, payment, enrollment or eligibility for benefits if I refuse to sign such authorization; and (3) information disclosed pursuant to this authorization is subject to re-disclosure by the Office of the Attorney General and will no longer be protected by HIPAA.

This authorization expires upon the conclusion of the investigation into the complaint by the Office of the Attorney General.

PLEASE NOTE: All patients 18 years of age and over must sign this consent form themselves, unless they have a legal guardian, personal representative or are incapacitated. If so, the signer must submit written proof of guardianship, representation or incapacity with this consent form. A parent or guardian must sign on behalf of an unemancipated minor.

Signature

Relationship

Date:
(mm/dd/yyyy)