**The State of New Hampshire**
**Insurance Department**
**21 South Fruit St., Suite 14**
**Concord NH 03301-2430**

Email: consumerservices@ins.nh.gov
Toll Free: 800-852-3416
Phone: 603-271-2261; Fax: 603-271-7066
TDD Access: Relay NH 1-800-735-2964
Website: www.nh.gov/insurance

**Christopher R. Nicolopoulos**
**Commissioner**

**David J. Bettencourt**
**Deputy Commissioner**

# Health Care Provider Complaints

**Important Information regarding the Insurance Department's Consumer Services Unit**

The Insurance Department's primary responsibility is to enforce the insurance laws and rules of the state. Consistent with that responsibility, the Department is prepared to address health care provider concerns which may be specific to individual patients – such as, denied claims and pre-authorization requests – or which may have a market-wide impact – such as unnecessary credentialing delays and carrier misapplication of accepted, medical standards (i.e., ASAM and MHPEA criteria).

In support of the Department's commitment to health care providers (HCP's), the Consumer Services Division (CSD) fulfills a threefold mission: educate providers and consumers about insurance products; assist those who request help navigating the complexities and intricacies of the health insurance industry; and investigate complaints involving the Department's licensees.

If you or one of your patients have a question, issue of concern or need assistance, please contact the Department's Consumer Services Unit at 800-852-3416 or via email at consumerservices@ins.nh.gov. If you believe one of the Department's licensees has violated a New Hampshire insurance law or regulation or if you wish to submit a formal complaint for any reason, please submit a Health Care Provider Complaint Form.

Upon receipt of your submission, the CSO assigned to your case will investigate your concern or forward your grievance to another Insurance Department business unit for consideration. In either case, you will receive written correspondence from the Department, informing you of the outcome of the Department's consideration or investigation. Please note, while not all submissions rise to the level of a formal complaint, the Department treats all submissions as confidential matters pursuant RSA 400-A:16.

If, after submitting your complaint, you have any questions, issues or concerns, do not hesitate to contact a CSO, toll free, at 800-852-3416.

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# General Instructions for the submittal of Health Care Provider Complaints

Grievances involving Health Care Providers fall into one of two (2) categories –Provider Complaint and Marketplace Complaint.

**Health Care Provider Complaint** – A formal grievance, ***related to patients or their claims***, submitted to the NHID directly by a health care provider.

1. Whereas this category of grievance relates to patients or their claims, the complainant (the provider) must also submit a "Release of Information Form" to the NHID with the requisite "Health Care Provider Complaint Form." This will permit the NHID to share information obtained about the patient's claim with the provider.
2. If the NHID receives a properly completed "Health Care Provider Complaint Form" and "Release of Information Form," the NHID will investigate the provider's grievance and shall provide the complainant (the provider) a response. The Department's response may include documents related to the patient's claim and may contain personal information, including personal health information (PHI).
3. If the requisite "Release of Information Form" is not received, the NHID will investigate the provider's grievance, but shall limit its response to the complainant (provider) to a disposition finding (e.g., "The Department has investigated your allegations of [description of allegation] and did not find any violation of New Hampshire insurance laws or regulations.").

**Marketplace Complaint** – A formal grievance, ***unrelated*** to patients or their claims which expresses dissatisfaction with the insurance marketplace or an NHID licensee, submitted to the NHID directly by a provider.

1. Whereas this grievance category does not relate to patients or their claims, a "Release of Information" is not required.
2. The NHID's Customer Services Unit will record all Marketplace Complaints and refer the cases to the appropriate NHID business Unit (i.e., Customer Services, Market Conduct, LAH Legal, etc.) for appropriate action.
    - If a Consumer Services investigation is conducted, the investigating Consumer Services Officer will provide the complainant (provider) a response which summarizes the disposition of the Department's findings (e.g., "The Department has investigated your allegations of [description of allegation] and did not find any violation of New Hampshire insurance laws or regulations.").
    - If your concern is forwarded to an NHID business unit other than Consumer Services, you will be contacted by a representative of that unit only if there is a need for additional detail about the situation you describe. Be advised, however, the information you submitted will be reviewed and considered by the Department, as it identifies opportunities and priorities for regulatory action.

**Grievance Submittal** – All requisite forms shall be submitted to the New Hampshire Insurance Department, Attn: Customer Services Unit, via post, fax or email at consumerservices@ins.nh.gov.

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# HEALTH CARE PROVIDER COMPLAINT FORM

## Section I – Health Care Provider (HCP) Information

Provider's Name: _____ Name of Practice: _____

Provider's NPI #: _____ Phone #: (_____)_____ Email: _____

Provider's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Applicant's Name:_____ Applicant's Email: _____

## Section II – Respondent or Health Carrier Information - Who is the complaint against?

Respondent's Name: _____

Respondent's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Respondent's Phone Number: (_____) _____

**Have you attempted to resolve this matter with the respondent?**

☐ No ☐ Yes If yes, on what date? _____

Name of individual you spoke with, if known: _____

Telephone Number (_____)_____ Email: _____

## Section III – Insured's Health Plan Information (If applicable)

Insured's Name: _____ Member ID or Policy #: _____

Claim/Reference #: _____ Date(s) of Service: _____

Type of Insurance: ☐ Health ☐ Dental ☐ Vision ☐ Disability ☐ Other _____

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## Section IV – Description of Grievance

Category of Dispute: ☐ Carrier Administration or Service ☐ Carrier-Provider Contract

☐ Credentials or Licensure ☐ Delayed or Rejected Claims

☐ Other (Please Describe) _____

**What is your complaint?**
Please describe your issue(s) of concern. Please attach copies of relevant documents.

_____

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_____

**Complaint Description** (Continued)

## Section V – Desired Outcome – What do you consider to be a fair resolution?

********** **COMPLAINT INVESTIGATION DISCLOSURE** **********

All submissions, including formal complaints, informational inquiries and assistance requests, are treated as confidential matters pursuant RSA 400-A:16, as they trigger investigations by the Department. Pursuant to RSA 400-A:16, II the Department may request and receive information and documentation, relevant to its investigation, from the named parties. Please note relevant information may include medical records. Also, the Department may share with the Department licensee any medical information and/or records provided in connection with this complaint.

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# RELEASE OF INFORMATION FORM

## Insured / Claimant Information

My Name: (Last) _____ (First) _____ (M.I.) _____

My Mailing Address: _____

City: _____ State: _____ Zip Code: _____

My Phone No. (_____)_____ My eMail Address: _____

## Insurance Information

Insurance Company Name: _____ Policy Number: _____

Insurance Company Phone No. (_____)_____ Claim Number: _____

## CONSENT AND RELEASE

Must be signed by the individual who is ***RELEASING*** insurance information

I hereby ***release*** my insurance information to _____ and I authorize the New Hampshire Insurance Department (NHID) to provide to this individual any insurance information related to my insurance claim described below and communications received from the insurance company, its agents or representatives. I understand that this information may include personal financial information, medical records, personal health information or other confidential information. I understand that it is possible that the person receiving this information may re-disclose this information to others. I discharge and release the NHID from any responsibility or liability related to the release of these records or any re-disclosure.

| _____ | _____ | _____ |
|---|---|---|
| Printed Name | Signature | Date |

## ACKNOWLEDGEMENT

Must be signed by the individual who will ***RECEIVE*** insurance information

I acknowledge that the above Release of Information will permit me to ***receive*** insurance information related to a claim filed by the individual signing the Release of Information. I understand that the NHID cannot disclose insurance information, if a Release of Information is not signed. I also understand the information I may receive may contain personal financial information, medical records, personal health information, or other confidential information.

| _____ | _____ | _____ |
|---|---|---|
| Printed Name | Signature | Date |