STATE OF NEW MEXICO
OFFICE OF SUPERINTENDENT OF INSURANCE

SUPERINTENDENT OF INSURANCE
Russell Toal

DEPUTY SUPERINTENDENT
Robert E. Doucette, Jr.

COMPLAINT FORM

The Managed Health Care Bureau will investigate your complaint to determine if there are any violations of the New Mexico Insurance Code, the Managed Health Care Rules or insurance policy language.

Name: _____ Date: _____

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: (Home) _____ (Work) _____ (Mobile) _____

Email: _____

Type of Complaint ____ Member _____ Provider Termination _____ Other _____

ID#: _____ Group #:_____

Name of Employer (if Group Plan): _____

Type of Healthcare Coverage: ___ Individual ___ Group

Type of Healthcare Plan:

__ HMO __ PPO __ Medicaid
__ State of NM __ NM Public Schools Authority __ NM Retiree Authority
__ Medicare __ Medicare Supplement Plan __ Self-Funded __ Other

Name of Insurance Company:
__ Presbyterian __ BCBS of New Mexico __ Molina __ Christus
__ United Healthcare __ NM Health Connections __ NM True Health __ Other

Complaint Type:

__ Co-pays __ Premium Payment __ Referral/Prior Authorization
__ Treatment __ Emergency Room __ Medical Necessity
__ Claim Denial __ Out of Network __ Other

Did you purchase your plan on the New Mexico Health Exchange (NMHIX)? __Yes __ No

Have you started the appeal process with your insurance company? __ Yes __ No

If yes, at what level is your complaint in the internal health plan's process?

__ Medical Director __ Internal Panel Review
__ Exhausted Internal Review __ Requesting an External Review

Main Office: 1120 Paseo de Peralta, Room 428, Santa Fe, NM 87501
Satellite Office: 6200 Uptown Blvd NE, Suite 100, Albuquerque, NM 87110
Main Phone: (505) 827-4601 | Toll Free: (855) 427 - 5674
www.osi.state.nm.us

Are you represented by an attorney or an authorized representative acting on your behalf with your consent? (See Section 13.10.17.30 (G) (1) NMAC)

If yes, (Please check one) Attorney: _____ Authorized Representative: _____

Name of Attorney or Authorized Representative:

_____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Telephone: _____

Email: _____

Please give a brief summary of your complaint and attach copies of any documents that are part of your complaint.

Complaint:

_____
_____
_____
_____

WHAT DO YOU FEEL IS A FAIR RESOLUTION TO THIS COMPLAINT?

_____
_____
_____

CONSENT TO RELEASE INFORMATION:

I, _____, hereby authorize_____,
(Your name) (Insurance Company)

to release all medical records, including nonpublic personal financial information, which are related to this compliant to the New Mexico Office of Superintendent of Insurance. I attest that the information provided in this application is true and accurate to the best of my knowledge. I understand that the New Mexico Office of Superintendent of Insurance will use this information to make a determination on my _____ appeal and that the information will be kept confidential and will not be released to anyone else without my permission. I understand that if the New Mexico Office of Superintendent of Insurance does not act as an attorney for private citizens. This release is valid for one year.

Complainant's Signature_____**Date**_____