

STATE OF NEW MEXICO
OFFICE OF SUPERINTENDENT OF INSURANCE

SUPERINTENDENT OF INSURANCE
Russell Toal



DEPUTY SUPERINTENDENT
Jennifer Catechis

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:

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> HMO | <input type="checkbox"/> PPO | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> State of NM | <input type="checkbox"/> NM Public Schools Authority | <input type="checkbox"/> NM Retiree Authority |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Medicare Supplement Plan | <input type="checkbox"/> Self-Funded ___ Other |

Name of Insurance Company:

- | | | | |
|--|--|---|-----------------------------------|
| <input type="checkbox"/> Presbyterian | <input type="checkbox"/> BCBS of New Mexico | <input type="checkbox"/> Molina | <input type="checkbox"/> Christus |
| <input type="checkbox"/> United Healthcare | <input type="checkbox"/> NM Health Connections | <input type="checkbox"/> NM True Health | <input type="checkbox"/> Other |

Complaint Type:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Co-pays | <input type="checkbox"/> Premium Payment | <input type="checkbox"/> Referral/Prior Authorization |
| <input type="checkbox"/> Treatment | <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Medical Necessity |
| <input type="checkbox"/> Claim Denial | <input type="checkbox"/> Out of Network | <input type="checkbox"/> 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?

- | | |
|--|--|
| <input type="checkbox"/> Medical Director | <input type="checkbox"/> Internal Panel Review |
| <input type="checkbox"/> Exhausted Internal Review | <input type="checkbox"/> Requesting an External Review |

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 complaint 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 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 _____