STATE OF NEW MEXICO
OFFICE OF SUPERINTENDENT OF INSURANCE

SUPERINTENDENT OF NSURANCE
Russel Toal

DEPUTY SUPERINTENDENT
Jennifer A.Catechis

INSURANCE HEALTH CARE PROVIDER COMPLAINT FORM

The New Mexico Office of Superintendent of Insurance investigates health care provider complaints filed against health care insurers such as health maintenance organizations, individual health plans, group and blanket plans, provider service networks, non-profit healthcare plans and third-party payers or their agents that provide, offer or administer health benefit plans subject to the insurance laws and regulations of this state. The Superintendent can assist with grievances regarding provider termination, discrimination, credentialing, timely payment of claims and other provider concerns in regards to the operations of the health insurer or plan.

Provider Information			
Name (First, Middle Initial, Last)			Title
NPI	E-mail Address		Phone
Practice/Group Name (If applicable)			
Address	City	State	Zip Code
Authorized Contact Name	E-mail Address		Phone

Insurance Company Information					
Name			Contracted: Yes ☐ No ☐		
Address		City	State	Zip Code	
Type of Plan:	HMO ☐	PPO ☐	EPO ☐	POS ☐	Other ☐

Complaint Type (Please check all that apply):				
Credentialing			Plan Operations	
Request Date	Response Date	Contract Date	Eligibility ☐ Prior Authorization ☐ Discrimination ☐	Termination ☐ Payment of Claims ☐ Other ☐
Have you already contacted the Insurance Company with this issue?				Yes ☐ No ☐
Is this complaint related to any previously submitted complaints?				Yes ☐ No ☐

Please describe your complaint, the attempts you have made to resolve the complaint, and the outcome you are requesting: (Attach additional pages, if necessary)

Copies of any correspondence between you and the Company, Uniform Bill and Customer Authorization Form (if applicable), are required.

Provider Signature: ____ Date: ____________

Please complete this page if your complaint involves a delay or denial of payment for a claim.

PATIENT AUTHORIZATION FORM

Claim Information			
Patient Name		Employer Name	Group #
Policy ID Number	Claim Number	Date of Service	Date of Claim Submitted
Date prior authorization requested and procedure or referral:			
Insurance Company Name			
Insurance Company Address			

Note: The release of individually identifiable health information requires written authorization from the patient.

I, ______________________________________ (Patient Name), authorize ______________________________ (Insurance Company Name) to release all medical records, including nonpublic personal health information and nonpublic personal financial information, which are related to this complaint, to the Office of Superintendent of Insurance. I authorize the release of such information, as necessary for the investigation, evaluation and resolution of my complaint, as allowed by law and on a need-to-know basis. I understand that my health insurer protects such information from unauthorized disclosure under federal and state law and other Office of Superintendent of Insurance rules and regulations. I understand that the Office of Superintendent of Insurance does not act as an attorney for private citizens.

Patient's Signature ____ Date ____________

BATCH COMPLAINTS

Insurance Company Information							
Name				Contracted		Yes	No
Address			City		State	Zip Code	
Type of Plan :	Individual	Group	HMO	PPO	EPO	POS	Other
Have you already contacted the Insurance Company with this issue?						Yes	No
Is this complaint related to any previously submitted complaints?						Yes	No

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