STATE OF NEW MEXICO

OFFICE OF SUPERINTENDENT OF INSURANCE

SUPERINTENDENT OF INSURANCE
Alice T. Kane

DEPUTY SUPERINTENDENT
Timothy Vigil

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 Deadlines ☐ Claim payment amount or timing ☐ Claim submission requirements or compliance

☐ Network adequacy, including participation determinations based on network composition ☐ Network composition including provider qualifications

☐ Utilization management practices ☐ Provider contract construction or compliance ☐ Patient care standards or access to care

☐ Surprise billing reimbursement amount, rate or timing ☐ Termination ☐ Operation of the plan ☐ Discrimination

Does this grievance pertain to Medicaid or Medicare coverage, excluding Medicare supplement?	**Yes** ☐	**No** ☐
Have you already contacted the Insurance Company with this issue?	**Yes** ☐	**No** ☐
Is this complaint related to any previously submitted complaints?	**Yes** ☐	**No** ☐

SANTA FE LOCATION (MAIN OFFICE)
(OVERNIGHT/SECOND DAY MAIL ONLY)
1120 Paseo De Peralta, 4th Floor
Santa Fe, New Mexico 87501

(USPS MAIL ONLY)
P O Box 1689
Santa Fe, New Mexico 87504

Main Phone: (505) 827-4601 | Toll Free: (855) 4 - ASK - OSI
www.osi.state.nm.us

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: _____

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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

Claim Information			
Patient Name		Employer Name	Group #
Policy ID Number	Claim Number	Date of Service	Date of Claim Submitted
Insurance Company Name			
Insurance Company Address			

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