Filing an Ethics and Fairness Complaint

The Ethics and Fairness in Carrier Business Practices Act (the Act), Section 38.2-3407.15 of the Code of Virginia, addresses the contractual relationship between carriers and providers. The Act applies to claims submitted by providers to carriers in connection with such contracts to the extent that the claim or claims are submitted to a health plan that is subject to state regulation and where coverage is provided under a policy issued in Virginia.

The Act does not apply to Medicaid, Medicare, Military insurance plans, Federal employee plans, Virginia employee benefit plans, self-funded employer health and welfare benefit plans, or workers compensation.

The Bureau will review the complaint to determine if it raises an Ethics and Fairness issue. If so, the Bureau will investigate to determine if the carrier's or the provider's conduct constitutes a general business practice or a pattern of potential violations. Our investigation may resolve the issues raised in an individual complaint; however, the State Corporation Commission does not adjudicate individual controversies arising out of the Act.

Failure to submit the provider contract will delay the investigation of the complaint.

Reset

4/2021

Ethics and Fairness Complaint Form

State Corporation Commission
Bureau of Insurance Life and Health Division
P.O. Box 1157 Richmond, VA 23218 | scc.virginia.gov/pages/Insurance
Toll-free: 1-877-310-6560 | Fax: (804) 371-9944

I am filing an Ethics and Fairness complaint against: *If you are complaining against more than one entity, please complete a separate form for each.*

Check one:

☐ Insurance Company (Name) _____

☐ Provider (Name) _____

Business Name: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Business Telephone: (____) _____ Fax No: (____) _____

Email: _____

Check if applicable:

☐ This complaint involves an allegation of a pattern of discrimination by a Provider against enrollees solely because of their status as a litigant in pending or potential litigation due to being involved in a motor vehicle accident.

Complainant Contact Information:

Name: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: (____) _____ Home Phone: (____) _____

Cell Phone: (____) _____ Email: _____

Details of my Ethics and Fairness complaint are explained below:

_____

_____

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Complainant Authorization:

I have enclosed copies of correspondence related to this complaint and authorize the BOI to send a copy of this form and any or all enclosed documents to the party complained against, other regulated entities, or the appropriate state or federal agency. I authorize the release of all medical records related to this complaint and authorize release of these medical records to the BOI and insurance company. I also authorize the BOI to obtain any information required to assist me.

Signature: _____ **Date:** _____

Complete form and submit along with copy of Provider Contract and supporting documentation to the address above.