PROVIDER COMPLAINT FORM

Please return this form and supporting documents to:

Mail:	Fax:	Email:
Bureau of Insurance Life and Health Division P.O. Box 1157 Richmond, VA 23218	(804) 371-9944	LHprovidercomplaints@scc.virginia.gov Please send by secure email

Questions: **Visit:** scc.virginia.gov/pages/Insurance
Toll free: 1-877-310-6560

The Bureau of Insurance (BOI) can investigate health care provider complaints involving health care plans that are subject to our oversight if the health carrier's actions constitute a pattern of potential violations of:

☐ *Ethics and fairness in a health carrier's practices with contracted providers (§ 38.2-3407.15 of the Code of Virginia); or*

☐ *Other insurance laws, regulations, or orders of the Virginia State Corporation Commission (the "Commission") (§ 38.2-237 of the Code of Virginia).*

Providers may contact the BOI for assistance with a complaint or with any questions.

I am filing a complaint against:
(Please complete a separate form for each insurance company involved in your complaint.)

Insurance Company: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

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

Provider Contact Information:

Name: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Preferred phone number: (____) _____ Email: _____

Is the provider a contracted, network provider with the insurance company complained against? ☐ Yes ☐ No

If you have a contract with the health carrier and are filing an ethics and fairness complaint, please include the provider contract and supporting documentation. This information is needed before we can contact the carrier regarding the complaint.

If your complaint involves issues of non-compliance under § 38.2-237 of the Code of Virginia, please provide details and evidence of non-compliance with insurance laws, regulations or orders of the Commission.

Describe the details of your complaint below: *(Please attach supporting documentation including any documentation noted above.)*

Provider Authorization:

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

Signature:_____ Date: _____

***Please note**: The Commission has no jurisdiction to adjudicate individual controversies arising out of §§ 38.2-3407.15 or 38.2-237 of the Code of Virginia. In addition, the Commission has no jurisdiction to adjudicate, as between two parties, matters of contractual dispute unrelated to Virginia's insurance laws, regulations, or Commission orders.*