Health Insurance Balance Billing Complaint Form

State Corporation Commission Bureau of Insurance

Toll-free: 1-877-310-6560 | Fax: (804) 371-9944 | scc.virginia.gov

According to Virginia law, an out-of-network provider can no longer balance bill or collect more than a covered person's in-network cost-sharing amounts **for dates of service on and after January 1, 2021,** related to (1) emergency services or (2) non-emergency surgical or ancillary services like lab or professional services, such as anesthesiology, pathology, radiology, and hospitalist services at an in-network facility.

You can call the Bureau of Insurance (BOI) for general information and assistance, or to confirm we are the appropriate agency to assist with your complaint. To file a complaint concerning balance billing, please complete this form. Additional information may be required.

I am filing a complaint against a(n): *If you are complaining against more than one entity, please complete a separate form for each.*

☐ Insurance Company ☐ Third-party Administrator ☐ Health Care Professional/Medical Provider

☐ Facility (hospital, ambulatory surgical center, or other health care facility)

Business Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Business Telephone Number: (____) _____ Website: _____

Please check all that apply:

☐ **Emergency services**

You received services from an out-of-network hospital, or an out-of-network doctor or other medical provider at a hospital.

☐ **Non-emergency surgical or ancillary services**

You received services at an in-network hospital or facility for professional services, including surgery, anesthesiology, pathology, radiology, or hospitalist services and laboratory services, that exceeds your in-network cost-sharing amount.

Complainant Contact Information:

Name: Mr./Ms. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: (____) _____ Work phone: (____) _____

Cell phone: (____) _____ Email: _____

Insured Contact Information (if different from complainant):

Name: Mr./Ms. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: (____) _____ Work phone: (____) _____

Cell phone: (____) _____ Email: _____

*****If more than one insured is involved, please attach a separate sheet with the requested information.*****

Policy/Policyholder Identification Information:

Source of Insurance Coverage: ☐ Individual ☐ Group:

_____

(If Employer Sponsored coverage provide the name of the Employer.)

Policy #: _____ ID#: _____ Certificate #: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Business phone: (____) _____ Fax Number: (____) _____

Describe your concerns:

For Medical Providers, Facilities, Insurance Companies, or Third-party Administrators filing this complaint, the below authorizations are not necessary.

Insured 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.

_____ **Date:** _____

Signature of Insured (if 18 or over) or parent or legal guardian (if Insured is under 18)

Representative Information and Authorization: Complete this section if you are NOT the Insured but are requesting help on behalf of the Insured. **Note:** For the BOI to help the Insured, the Insured or applicable parent or legal guardian will have to sign this form unless the Insured is deceased, incapacitated, or under 18 years of age.

Name: Mr./Ms. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: (____) _____ Work phone: (____) _____

Cell phone: (____) _____ Email: _____

I, _____, (Insured, parent or legal guardian), authorize the BOI to: (i) discuss this complaint with, and (ii) share medical information related to this complaint with _____ (Authorized Representative). **Note:** This authorization is not necessary if the Representative is the parent or legal guardian of an Insured under 18 years of age, or if the Insured is deceased or incapacitated.

_____ **Date:** _____

Signature of Insured (if 18 or over) or parent or legal guardian (if Insured is under 18):