



STATE OF NEW YORK
INSURANCE DEPARTMENT
ONE COMMERCE PLAZA
ALBANY, NY 12257
(800) 342-3736 Fax (518) 474-2188

PROVIDER PROMPT PAYMENT COMPLAINT FORM

Name of Provider	Complaint against (Insurer or HMO)
Address	Address
City State Zip	City State Zip
Contact/Phone	
Patient Name	ID number
Date of Service	Claim number (if available)
Date(s) claim submitted	Has an appeal been filed for this claim? If so when?
Type of coverage (i.e. HMO, Indemnity, Medicaid, Self-funded*, Medicare*) -* see #2 below	

The Insurance Department investigates insurance complaints against licensed insurance entities. You will receive a written acknowledgement with your file number(s) by mail. This Department cannot: act as your lawyer, give legal advice, recommend, or rate insurers.

Before contacting this Department regarding an alleged prompt pay violation, please do the following:

- 1) Contact the insurer or HMO to verify that the claim was received.
- 2) Make every effort to determine the type of coverage. If the patient is covered by a self-funded plan or Medicare this Department lacks jurisdiction to assist.
- 3) Review your records to ensure claim has not been paid or denied.
- 4) If the insurer or HMO has requested additional documentation and you have not supplied it, the claim is not delinquent and should not be submitted as a complaint.

In order to process your complaint this Department requires:

- A. A legible copy of the HCFA 1500 or UB 92 form for each claim. Do not send originals!
- B. When sending in numerous claim forms, please group them by insurer or HMO and alphabetize by patient.
- C. Do not send duplicate complaints. Once you have filed a complaint, do not re-submit it with another batch even if it is still outstanding.