Minnesota Department Of Health
Managed Care Section
P.O. Box 64882
St. Paul, Minnesota 55164-0882
(651) 201-5100 or 1-800-657-3916
Fax: 651 201-5179 E-mail: mcs@health.state.mn.us

# HMO Complaint

▶Instructions

1. In order to assist you in addressing your complaint, you must complete this form including the Consent to Release.
2. Submit the completed form to the address above in the enclosed envelope or fax it to the number above.
3. Contact us at the number above if you have questions regarding the processing of your complaint.
4. Based on the information you supply, we will do our best to help you resolve your complaint.

| Name of Person Submitting Complaint | Daytime Phone | Alternate Phone |
|---|---|---|
| Street Address | | |
| City | State | Zip |
| Name of enrollee for whom you are filing this complaint (if you are not filing for yourself). | Relationship to enrollee | |
| Email Address: | | |
| Name of HMO (Check one.)<br>☐ Blue Plus ☐ Itasca Medical Care ☐ PrimeWest<br>☐ First Plan ☐ Medica ☐ Sioux Valley<br>☐ Group Health/HealthPartners ☐ Metropolitan Health Plan ☐ South Country<br>☐ Preferred One ☐ UCare | | |
| Type of Coverage<br>☐Group ☐Non group ☐ PMAP ☐ MinnesotaCare<br>☐ Medicare ☐Other | Enrollee/Membership Number | Date of Birth |
| Name of Enrollee's Primary Clinic/Primary Care Physician | | Date(s) of Incident |

What would you like to see happen to resolve this complaint?

## Tennessen Warning

1. The **Minnesota Government Data Practices Act** requires that we provide you with the following information:

a) the purpose and intended use of the data you provide is to help the Minnesota department of health investigate and take action on your complaint.
b) you are not legally required to provide any data to the department and you may refuse to provide any data
c) any data you provide may be used in a legal action that the department brings against an HMO. You may be asked to testify in a legal action. If you do not provide the requested data, the department may not be able to fully investigate and take action on your complaint
d) the data you provide may be disclosed to certain persons or entities including individual staff members within the department whose job requires them to handle the complaint material, outside experts, the Office of the Attorney General, the Office of Administrative Hearings, any court with jurisdiction, and other agencies that have legal authorization to obtain the data.

2. As part of your complaint, the department may find it helpful to send a copy of your complaint to your HMO. Unless you tell us not to, a copy of your complaint may be sent to your HMO.

☐ **Do not send a copy of my complaint to my HMO.**

3. The department may find it helpful to identify you to the HMO as the person who submitted this complaint. Unless you tell us not to, we will identify you as the person submitting the complaint.

☐ **Do not identify me as the person who submitted the complaint.**

Please be advised that after our investigation is closed, an individual who is the subject of stored data has the right to see the data upon request. If you are filing information on behalf of another person, the information you provide will become part of the complaint file and may be seen by the subject of the data once the complaint is closed.

**Narrative description of your complaint:** In the space below, tell us what happened including when and where it happened and who was involved. If possible, include the full names of any involved individuals from the HMO, the clinic, the hospital or any other provider. If possible, attach copies **(do not send originals)** of any relevant documents such as referrals, denials, prior authorizations, bills, explanation of benefits, and written correspondence. Attach additional sheets if necessary.

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# Instructions for Consent to Release

It may be necessary to obtain copies of protected health information, health records or health data in order for MDH to fully investigate your complaint. We must have the **patient's** signed permission in order to obtain protected health information, health records or health data. We have provided a Consent for Release which will be used to obtain protected health information, health records or health data from your providers. The **patient** should sign and date the enclosed Consent to Release and return it in the envelope provided.

The list of providers may include clinics, physicians, hospitals, pharmacies and any other provider that may have protected health information, health records or health data relevant to your complaint. For each provider listed, please indicate the dates of service, or time period, that is relevant to your complaint.

For example:

| | |
|---|---|
| Hospital X | May 1 – May 9, 2006 |
| Dr. Y | April – June, 2006 |
| Clinic Z | April – June, 2006 |

You may contact us at 651-202-5100 if you have any questions about filling out this form.

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# Consent To Release

| Patient's Name | Patient's Birth Date |
|---|---|
| Patient's HMO | HMO ID Number |

By signing this form, I give permission to my HMO and to the provider(s) listed below to provide a copy of my protected health information, health records or health data to the Minnesota Department of Health (MDH), or to allow them to be inspected and/or copies to be provided to the MDH. I give permission for the provider(s) listed below to testify without limitations as to any and all findings and/or treatment referred to in them. I release my HMO and the provider(s) listed below, MDH and its agents, and the agents of the Office of the Attorney General representing MDH from liability for releasing my protected health information, health records or health data or from testifying. I waive any privilege afforded me by law relating to the disclosure of introduction into evidence of protected health information, health records or health data. I also authorize MDH to use my name and/or protected health information, health records or health data in any legal proceeding arising out of this matter.

I understand that all protected health information, health records or health data pertaining to psychiatric/mental health, including chemical dependency, drug or alcohol abuse treatment protected health information, health records or health data, may be released unless indicated here:

☐ Do not release protected health information, health records or health data related to psychiatric/mental health treatment.
☐ Do not release protected health information, health records or health data related to chemical dependency/drug/alcohol abuse treatment.

This release takes effect on the date I sign and is good for 12 months or until the conclusion of the MDH investigation including any legal actions taken by MDH, whichever comes first. I may cancel this consent at any time by notifying the provider(s) listed below in writing. My cancellation will not have any effect on information released before the provider(s) received my written notice of cancellation.

| Patient/Guardian Signature | Date |
|---|---|
| Relationship to Patient (if signed by guardian) | Reason Patient unable to sign |

| **Provider(s)** Use back for additional providers. | **Date(s) of Service** |
|---|---|
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