LISA MADIGAN
ILLINOIS ATTORNEY GENERAL
Health Care Bureau
100 West Randolph Street
Chicago, Illinois 60601
Hotline Number: 1-877-305-5145; Fax Number: 1-312-793-0802
TTY: 1-312-964-3013; Website: www.IllinoisAttorneyGeneral.gov

Your Information

Your Name: ☐Mr. ☐ Mrs. ☐Ms.

_____

Mailing Address:

_____

City: State: Zip Code: County:

_____

Daytime Phone No.: Evening Phone No.:

_____ _____

E:mail Address (Optional):

_____

Patient's Information

Patient's Name:

_____

Address:

_____

City: State: Zip Code: County:

_____

Phone No.: Date of Birth:

_____ _____

Senior Citizen? ☐ Yes ☐ No

Your Complaint Is Against (Respondent)

Name: _____Contact Person:_____ Phone:_____

Street Address:_____ City/Town:_____State:___Zip:_____County:_____

Account No.:_____Date of Service:_____Is the claim in collections? ☐Yes ☐No

If yes, please provide name, phone, account, and contact person:_____

_____

Total Cost:_____ Amount Paid:_____Money Owed:_____By Whom (i.e., Ins. Co.)_____

How Paid:(i.e., cash, check, credit card, etc.):_____Have you complained to the company/individual? ☐ Yes ☐ No

Complained by: ☐ Mail ☐Phone ☐ In Person ☐ Facsimile ☐ Other_____

Person Contacted:_____ Job Title:_____Phone No.:_____

Nature of response:_____Date of response:_____

Did you sign a contract? ☐ Yes ☐ No. If yes, please attach a copy.

Was the product/service advertised? ☐Yes ☐ No. Please attach a copy of the advertisement, if available.

Who referred you to this office?_____Is court action pending? ☐ Yes ☐ No

Has this matter been submitted to another agency/attorney? ☐ Yes ☐ No. If yes, please provide the name and phone number.

_____

Primary Insurance Information At The Time of Service

Insurance Name:_____Contact Name:_____Phone No.:_____

Address:_____City/Town:_____State:____Zip:_____County:_____

Type of Plan: ☐ HMO ☐ PPO ☐ Dental ☐ Medicare ☐ Supplemental ☐ Other _____

Employer Name:_____Phone No.:_____Self Insured? ☐ Yes ☐ No

Employer Address:_____City/Town:_____State:____Zip:_____County:_____

Policy Holder:_____Group:_____ID#:_____

Secondary Or Supplemental Insurance At The Time of Service

Insurance Name:_____Contact Name:_____Phone No.:_____

Address:_____City/Town:_____State:____Zip:_____County:_____

Type of Plan: ☐ HMO ☐ PPO ☐ Dental ☐ Medicare ☐ Supplemental ☐ Other _____

Policy Holder:_____Group:_____ID#:_____

A Description of Your Problem. (Please use additional paper, if necessary. Also, attach copies of all documents related to your complaint). PLEASE DO NOT SEND ORIGINALS.

_____

_____

_____

_____

_____

_____

Type of Resolution/Relief You Are Seeking. (i.e., exchange, repair, money back, product delivery, etc.).

_____

In filing this complaint, I understand that the Attorney General is not a private attorney, but rather enforces laws designed to protect the public from misleading or unlawful business practices. I also understand that if I have any questions concerning my legal rights or responsibilities, I should contact a private attorney. I have no objection to the contents of this complaint being forwarded to the business or the person the complaint is directed against, unless box checked below. The above complaint is true and accurate to the best of my knowledge.

_____ _____

Signature Date

☐ Check here if you only want to notify our office of your concerns and do not want a mediation process initiated.

We recommend that you print an additional copy(s) of this filled out form for your records