DIFP
Department of Insurance, Financial Institutions & Professional Registration

Provider Credentialing Complaint

MAIL TO
Missouri DIFP
PO Box 690
Jefferson City, MO 65102
800-726-7390
573-751-2640
TDD: 573-526-4536

Please complete all information and enclose copies of correspondence, screen shots or other documentation that will help us understand your complaint. Send this form and attachments to the above address.

PLEASE PRINT, TYPE OR WRITE CLEARLY IN BLACK OR BLUE INK

1 PROVIDER INFO

PROVIDER NAME _____ **PHONE** _____ **TAX ID NO.** _____

ADDRESS _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP CODE) _____ (COUNTY)

EMAIL _____ **CONTACT PERSON** _____

PRACTITIONER TYPE. Please select which applies to you:

- ☐ Physician
- ☐ Physician assistant
- ☐ Pharmacist
- ☐ Podiatrist
- ☐ Chiropractor
- ☐ Optometrist
- ☐ Dentist
- ☐ Psychologist
- ☐ Licensed clinical social worker
- ☐ Advance practice nurse
- ☐ Other _____

2 COMPANY INFO

HEALTH CARRIER NAME (INSURANCE COMPANY or HMO) _____

DATE CREDENTIALING APPLICATION WAS SENT TO HEALTH CARRIER

_____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

_____ MM/DD/YYYY

ADDRESS WHERE CREDENTIALING FORM WAS MAILED — LEAVE BLANK IF FILED ELECTRONICALLY:

_____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP CODE)

HOW APPLICATION WAS SENT

- ☐ Electronically
- ☐ Fax or mail

3 REASON FOR COMPLAINT

The law recognizes the following potential violations:

- ☐ No notice of receipt of credentialing application
- ☐ Notice of receipt of credentialing application not timely
- ☐ No access to provider Web portal
- ☐ Decision to approve or deny not made timely
- ☐ Other _____

4 DOCUMENTATION & SIGNATURE

Attach copies of any documentation that will help identify the health plan that has allegedly violated the state credentialing law, and the nature of the alleged violation, such as cover letters, screen shots if the credentialing form was filed electronically, or correspondence.

SIGNATURE _____ DATE (MM/DD/YYYY) _____