Teachers Health Trust

# Participant Complaint/Concern Form

## Participant Information

Participant Name (Last, First, Middle Initial) _____ ID Number _____

Patient Name (if different from above) _____ Relationship to Participant: ○ Self ○ Dependent

Street Address _____ City _____ State _____ Zip _____

Email Address _____ Phone _____ Date of Birth _____

### Privacy

○ Share All - Please share my concerns, comments or complaints, as necessary.
○ Do Not Share - This information is confidential. Please do not share.

## Complaint/Concern Information

Please specify which department your complaint and/or concern applies to. (select all that apply)

☐ Authorization (Section A) ☐ Benefits & Eligibility (Section B) ☐ Provider/Network Relations (Section C)
☐ Member Services (Section D) ☐ Claims (Section E) ☐ Life Insurance (Section F)
☐ Dental (Section G) ☐ Vision/VSP (Section H) ☐ Other (Section I)

Please complete the sections that correspond to your selections above.

## A. Authorization

**NOT APPLICABLE** ☑

○ I am requesting information regarding my appeal. ○ I would like to appeal a denied authorization.*

1. Please provide a complete and detailed explanation of your case and issue. Attach additional pages as needed.

2. Requesting Office Information (your provider who requested the authorization):

Provider Name _____ Provider Group _____

Practice Address _____ City _____ State _____ Zip _____

Procedure/Medication Requiring Authorization _____

Potential Date of Procedure _____ ○ Urgent ○ Non-Urgent

* If you wish to change your PCMH provider, please complete and submit the Provider Change Request Form located on the Teachers Health Trust website, along with the Consent to Discuss/Disclose Personal Protected Health Information (PHI) Form for dependents under 18 years of age.

## B. Benefits and Eligibility

NOT APPLICABLE ☑

○ I am requesting clarification of benefits.

○ I have questions regarding coverage (including COBRA)

Please provide a complete and detailed explanation of your case and issue. Attach additional pages as needed.

## C. Provider/Network Relations

NOT APPLICABLE ☑

○ I am filing a complaint against a provider/office.*

○ I have questions regarding the network.

○ I would like to appeal for an out-of-network provider to be included in-network.

1. Please provide a complete and detailed explanation of your case and issue. Attach additional pages as needed.

2. Provider Information:

Provider Name _____ Provider Group _____

Practice Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Name of staff members who were present at, witness to and or involved with concern/complaint (if applicable) _____

* If you wish to change your PCMH provider, please complete and submit the Provider Change Request Form located on the Teachers Health Trust website, along with the Consent to Discuss/Disclose Personal Protected Health Information (PHI) Form for dependents under 18 years of age.

## D. Member Services

NOT APPLICABLE ☑

1. Please provide a complete and detailed explanation of your case and issue. Attach additional pages as needed.

2. Customer Service Representative Information:

Service Representative Name _____ Date of Interaction _____ Time of Interaction _____

## E. Claims

NOT APPLICABLE ☑

- ○ I would like to file a claims appeal.
- ○ I am requesting information regarding a claim.
- ○ I would like to dispute charges I was billed.

Please provide a complete and detailed explanation of your case and issue. Attach additional pages as needed.

Please attach any relevant documents of billing statements, collection notices, receipts, and any other documents in support of your case. Providing as much detailed information will assist the Trust in processing your comments.

## F. Life

NOT APPLICABLE ☑

Please provide a complete and detailed explanation of your case and issue. Attach additional pages as needed.

## G. Dental

NOT APPLICABLE ☑

- ○ I am filing a complaint against a dentist/orthodontist office.
- ○ I have questions regarding the network.
- ○ I would like to appeal for an out-of-network provider to be included in-network.

1. Please provide a complete and detailed explanation of your case and issue. Attach additional pages as needed.

2. Provider Information:

Provider Name _____ Provider Group _____

Practice Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Name of staff members who were present at, witness to and or involved with concern/complaint (if applicable) _____

## H. Vision

**NOT APPLICABLE** ☑

- ○ I am filing a complaint against a optometrist/vision office.
- ○ I have questions regarding the network.
- ○ I would like to appeal for an out-of-network provider to be included in-network.

1. Please provide a complete and detailed explanation of your case and issue. Attach additional pages as needed.

2. Provider Information:

Provider Name _____ Provider Group _____

Practice Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Name of staff members who were present at, witness to and or involved with concern/complaint (if applicable) _____

## I. Other

**NOT APPLICABLE** ☑

Please provide a complete and detailed explanation of your case and issue. Attach additional pages as needed.

SUBMIT FORM