BEHAVIORAL HEALTH PARITY COMPLAINT FORM

☐MS. ☐MRS. ☐MR. NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ E-MAIL: _____

Have you reported this issue to the Attorney General's Office, Executive Office of Consumer Affairs, or other government agency? If yes:

Name of Agency: _____ File No.: _____

1. **Is your complaint related to your health insurance plan?**

   ☐ Yes. Please proceed to Section 2.

   ☐ No. Do not fill out this form. This form may only be used for complaints related to health insurance. If you have a complaint not related to health insurance, please contact the DOI's general complaint line at: [xxx-xxxx]

2. **Is your complaint related to a behavioral health service or treatment?**

   "Behavioral health" includes mental health conditions, substance use disorder/addiction, eating disorders, and autism spectrum disorders.

   ☐ Yes. Please proceed to Section 3.

   ☐ No. Do not fill out this form. If you have a health insurance complaint not related to behavioral health, please contact the DOI's general complaint line at: [xxx-xxxx]

3. **Health Insurance Information**

Health Insurance Carrier: _____

Behavioral Health Management Co. ("carve-out"), if applicable: _____

Group/Certificate Number: _____ Policy/ID # _____

If insurance is provided through employment, Employer's Name (optional):

_____

4. Complaint Details

(a) Have you received a written adverse benefit determination (e.g. denial letter) from your health plan?

☐ Yes. Please attach a copy of the written denial to this complaint form. You may redact any sensitive information you do not wish to disclose.

☐ No. Please describe how you were notified of the adverse determination:

_____

(b) Reason for denial or limitation of coverage (mark all that apply):

☐ Service not medically necessary
☐ Excluded benefit
☐ Service is experimental or investigative
☐ Reached annual visit limit
☐ Reached annual dollar limit
☐ Out-of-network
☐ No prior authorization/approval
☐ No reason given
☐ Other: _____

(c) If the denial was based on medical necessity, did your health plan provide you with a copy of the medical necessity criteria used?

☐ Yes. Please attach a copy of the criteria to this complaint form.

☐ No / I don't know.

(d) Have you filed an appeal with your health plan and/or with the Office of Patient Protection? (mark all that apply)

☐ Yes, filed an appeal with the health plan.

☐ Denial upheld
☐ Denial overturned
☐ Denial partially overturned
☐ Appeal pending

☐ Yes, filed an appeal with the Office of Patient Protection (OPP).

☐ Denial upheld
☐ Denial overturned
☐ Denial partially overturned
☐ Appeal pending

☐ I have not filed any appeals.

(e) Complaint Description (please attach additional pages if necessary):

I authorize the release of any information regarding this complaint to help the Division of Insurance with their review. **I acknowledge that complaints and inquiries filed are not confidential**. I authorize the Division of Insurance to refer this complaint to any government agency when deemed appropriate by the Division of Insurance.

Signature: _____ Date: _____