Form AID-CS-Provider (9/06)

Arkansas Insurance Department

HEALTH CARE PROVIDER COMPLAINT FORM

1 HEALTH CARE PROVIDER INFORMATION

Name _____

Address _____

City _____ State ___ Zip _____

Phone No. _____ I.D. No._____

Area of Practice _____

Is this a managed care entity? Yes ☐ No ☐

If so, are you an HMO, PPO, IPN, Self-funded Medicare HMO or Medicaid HMO? _____

Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Phone: 501-371-2640 or 800-852-5494
Fax: 501-371-2749
E-mail: insurance.consumers@arkansas.gov
Web site: www.insurance.arkansas.gov

2 PATIENT/INSURER INFORMATION

Patient's Name _____

Patient's Address _____

Name of Insured _____

Insurance Company _____

Policy No. _____ Group/Plan Number _____

3 Explain below the problem you are experiencing. Also, please attach copies of any information you believe will be helpful to the Department regarding this complaint/inquiry.

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Release of Information: My signature on this form constitutes my authorization for the Arkansas Insurance Department to obtain any information or documentation from any legal entity it deems necessary for the resolution of my complaint/inquiry. A photocopy of this form will be considered valid authorization.

SIGNATURE _____ **DATE** _____