

# Managed Care Patient Assistance Program

Helping North Carolina ~ One Patient at a Time

## Inquiry Form

PERSON FILING INQUIRY

DATE:	LAST:	FIRST:	M.I.:
HOW DID YOU HEAR ABOUT THIS OFFICE: <input type="checkbox"/> TV <input type="checkbox"/> Newspaper <input type="checkbox"/> Internet <input type="checkbox"/> AG <input type="checkbox"/> Insurer <input type="checkbox"/> DOI <input type="checkbox"/> Other _____			
INDICATED BEST # TO CALL: <input type="checkbox"/> WORK <input type="checkbox"/> HOME <input type="checkbox"/> PAGER <input type="checkbox"/> CELLULAR PHONE ( ) -			
HOME PHONE #:		WORK PHONE #:	
ADDRESS:			CITY:
COUNTY:	STATE:	ZIP CODE:	DOB:
GENERAL DESCRIPTION OF ISSUE:			

### PATIENT DEMOGRAPHIC INFORMATION

CHECK IF NAME AND ADDRESS IS THE SAME AS ABOVE.

LAST:	FIRST:	M.I.:	
PATIENT'S RELATIONSHIP TO PERSON FILING COMPLAINT:			
ADDRESS:			
CITY:	COUNTY:	STATE:	ZIP CODE:

### LOOK ON INSURANCE CARD FOR THE FOLLOWING INFORMATION:

Insurance Company:
Phone # ( )
Type of Health Plan: <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Indemnity
<input type="checkbox"/> Medicare <input type="checkbox"/> Medicare supplemental <input type="checkbox"/> Don't know
<input type="checkbox"/> Self funded <input type="checkbox"/> Group <input type="checkbox"/> Other <input type="checkbox"/> None
Start Date: End Date:
Policy Holder's Name:
Patient's Policy Number:
Group Name:
Group / Contract Number:
Patient's Relationship to Policy Holder:

### TREATING HEALTH CARE PROVIDER INFORMATION

Name of Provider:
Phone # ( )
Procedure:
Dates of Service:
Type of Provider: <input type="checkbox"/> Doctor <input type="checkbox"/> Chiropractor <input type="checkbox"/> Nurse <input type="checkbox"/> Hospital <input type="checkbox"/> RX Drug <input type="checkbox"/> Other _____

### GRIEVANCE / APPEAL:

Date grievance filed with insurer: _____
By: <input type="checkbox"/> Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In person
Process Stage: <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> External Review
Complaint Outcome: <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> N/A
Name of contact at insurer: _____
Phone number: ( ) _____

**ADDRESS: MANAGED CARE PATIENT ASSISTANCE PROGRAM**  
CONSUMER PROTECTION DIVISION  
NORTH CAROLINA DEPARTMENT OF JUSTICE  
POST OFFICE BOX 629  
RALEIGH, NORTH CAROLINA 27602 - 0629

**TELEPHONE:** TOLL FREE: 866-867-MCPA (6272)  
919-733-MCPA (6272)  
FAX: 919-733-6276  
**OFFICE HOURS:** MONDAY - FRIDAY 8:00 AM - 5:30 PM  
**EMAIL:** MCPA@NCDOJ.COM

**ATTORNEY GENERAL ROY COOPER**

**ADDITIONAL IMPORTANT INFORMATION:**

Have you complained to any other state or federal agencies? Yes No

Name of agency \_\_\_\_\_ Agency Response: \_\_\_\_\_

\_\_\_\_\_ Contact name at agency: \_\_\_\_\_

Have you retained an attorney? Yes No Attorney's Name and Phone Number : \_\_\_\_\_

Have you filed a court action? Yes No Docket Number: \_\_\_\_\_ State: \_\_\_\_\_

**Please explain the complaint in detail.** You may use additional sheets, if necessary. Please write or type clearly. Try to be brief, but be sure to tell - **what** happened, **when** it happened, **where** it happened, and with **whom** you have spoken to resolve the issues. Describe events in the order in which they occurred. Attach **copies** of the front and back of your insurance card, insurance handbooks, EOBs (explanation of benefits), contracts, medical bills, correspondence including copies of e-mails, and receipts.

Large empty rectangular box for writing the complaint details.

**Please state the specific resolution you are seeking.**

Small empty rectangular box for stating the resolution sought.

All information obtained by this office is considered confidential. The information will not be disclosed to other parties without my prior written consent. By signing my full name and providing the date in the space provided below, I will submit this form and certify that the information provided in this complaint form, including my identity and any factual statements or allegations, are **true and correct** to the best of my knowledge or information and belief. **I authorize the Office of Attorney General, Managed Care Patient Assistance Program, to provide a copy of this consumer complaint to my health care plan.**

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**NEXT STEPS:**  INQUIRY CLOSED DATE \_\_\_\_\_  ASSIGNED CASE NUMBER \_\_\_\_\_ DATE CASE CLOSED \_\_\_\_\_

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# Authorization for Release of Medical Records Forms

I, \_\_\_\_\_ on behalf of \_\_\_\_\_  
Person Authorizing Release Print Patient's Name

hereby authorize any physician, medical practitioner, hospital or medically related facility, insurance company, managed care organization, or other institution or person to release to the Office of the Attorney General, Managed Care Patient's Assistance Program or its authorized representatives, all or any such medical/insurance records including applicable mental health records and/or substance abuse treatment information and records. The purpose of this disclosure is to allow the Office of Attorney General to investigate a complaint filed by me or on my behalf.

Medical records shall include all past, present, or future medical information or knowledge of medical information, medical reports, physical examination reports, hospital reports, opinions concerning my health, or x-ray reports relating to me or my health.

All persons to whom the confidential information is disclosed pursuant to my consent shall maintain the confidentiality of such information, and not disclose it to any other person in any form, without my prior written consent. I also understand that this authorization for release of information may be revoked or withdrawn at any time and revocation or withdrawal will apply to all information not previously released to the Managed Care Patient's Assistance Program. This authorization is valid as long as my file is open and active in the Office of Attorney General. I also agree that a photocopy or facsimile of this authorization shall be as valid as the original.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Patient's Name (print) \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_

Patient's Social Security Number \_\_\_\_\_

**THIS MEDICAL RELEASE IS NOT MANDATORY. HOWEVER, FAILURE TO SIGN THIS RELEASE MAY PREVENT FURTHER ASSISTANCE ON YOUR COMPLAINT.** Please complete the Inquiry Form and sign the Authorization for Release of Medical Records Form. Attach photocopies of all relevant documents and records as originals **cannot** be returned.

**MAIL THESE DOCUMENTS TO:** Managed Care Patient Assistance Program  
Consumer Protection Division  
Office of the Attorney General  
Post Office Box 629  
Raleigh, North Carolina 27602-0629

Or

**FAX THESE DOCUMENTS TO:** (919) 733-6276