



Provider/Member Complaint Form

Name _____ Name of Insurance COMPANY this complaint is about (HMO, health carrier, etc) :

Address _____ Date of Service or Date of Loss (Date of Treatment): _____

City _____ State _____ Zip _____ Has the Patient filed a complaint with the State? Yes No

If not, will they consider filing a complaint? Yes No

Home Phone: _____ Work Phone: _____ Have YOU filed a complaint with the State? Yes No

Type of Insurance Complaint is about:

Auto Workers Comp Blue Cross/Blue Shield HMO Other Health/Insurance (Name): _____

Is This an Employer or Group Plan?

Yes No If Yes, enter employer name, group name, or group number: _____

Details of Complaint:

- Patient's policy has a yearly limit on chiropractic services inclusive to the amount of _____, without such yearly limits on visits to other physician groups.
- Patient's policy has annual chiropractic visit limits, without such visit limits when they see other physicians.
- Patient's policy limits the number of procedures (services) if performed on the same day by a doctor of chiropractic, but has no limits on procedures on the same day if performed by other physicians.
- Patient's policy excludes procedures (services) rendered by doctors of chiropractic (HMO).
- Patient's policy has a higher co-pay for the same procedure (service) when performed by a doctor of chiropractic than it does for other physicians.
- Other (please explain): _____
(Attach additional pages, if needed) _____

*Reviewing documentation often helps us understand important details of your complaint. Please attach copies of EOBs, denial letters, formal policies, contracts, or other documents that will help us review your complaint. This could include your patient's insurance card, bills, receipts, a policy declaration sheet, claim documentation, or other items that relate to your complaint. **Always remember to "black out" the patient's name and ID numbers before you send the information.** Arranging your documents in the order events took place helps us gain a quicker understanding of your complaint. **Always send copies. Never send original documents.***

Please Return Complaint to: Michigan Association of Chiropractors
416 W. Ionia, Lansing, Michigan 48933
Phone: (517) 367-2225 Toll-Free: (800) 949-1401
Fax: (517) 367-2228 Email: info@chiromi.com