

**DEPARTMENT OF INSURANCE****HEALTH CLAIMS BUREAU**

300 SOUTH SPRING STREET, SOUTH TOWER

LOS ANGELES, CA 90013

[www.insurance.ca.gov](http://www.insurance.ca.gov)

CSD-004

Eff. 01/07/2019

**HEALTH CARE PROVIDER REQUEST FOR ASSISTANCE (HPRFA)**

Patient's Name:	Patient's Date of Birth:	Patient's Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Provider Contact Name (Last, First):		
Provider/Facility Name:		
Provider Address:	City:	Zip:
Phone Number:		
E-mail Address:		

**Before you file for a case review with the Department of Insurance, you should first exhaust the Dispute Resolution (DR) process with the insurance company. The insurer is required to resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute.**

**To ensure proper review of the case, a copy of the completed Health Care Provider Request for Assistance form and other documentation submitted by you will be provided to the insurance company, agent or the broker.**

Primary policyholder's name if different than the patient:	
Patient's primary language spoken at home:	
In order to ensure all Californians have access to health insurance, please identify patient's race/ethnicity. One or more categories may be selected: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Decline to State	
Complete name of insurance company involved:	
Type of Insurance: Individual Health <input type="checkbox"/> Group Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medicare Supp <input type="checkbox"/>	
Do you have an existing contract with the insurance company? Yes <input type="checkbox"/> (Provide copy) No <input type="checkbox"/>	
Have you contacted the insurance company and exhausted the Internal Dispute Resolution Process? Yes <input type="checkbox"/> (Provide copies of all correspondence) No <input type="checkbox"/>	
Were services rendered in an in-network facility? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Were services related to emergency care? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Claim Number:	Policy/Certificate/ID Number:
Group Name:	Group Number:



Date(s) of Medical Service(s) Provided:
CPT Codes:
Does the complaint concern the payment of a specific claim? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, provide: Billed Amount \$ _____ Paid Amount \$ _____ Amount in Dispute \$ _____
Have you reported this to any other governmental agency? Yes <input type="checkbox"/> No <input type="checkbox"/>
Name of agency: _____ File number, if known: _____
Have you previously written to the Department of Insurance about this matter? Yes <input type="checkbox"/> No <input type="checkbox"/> File number (if available) _____
Are you represented by an attorney in this matter? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the case currently in active litigation? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, we will defer the regulatory investigation until the finality of the litigation. We ask that you still complete this form so we have a record of your issue. Once the matter is concluded, we would welcome any information regarding violations of insurance law by the insurer that you or your attorney are willing to provide.
Briefly describe the disputed issue. Use additional paper as needed.

The following documents must accompany this form. Failure to provide all or any part of the information requested may preclude or delay the Consumer Services Division of the Department of Insurance from reviewing your complaint.

- Copy of the patient's (signed) Assignment of Benefits, if applicable
- Copy of claim forms submitted to the insurance company (UB 92, HCFA 1500, etc.)
- Copies of all correspondence between the provider and the insurance company, including all related EOBs
- Copy of the Dispute Resolution Process determination letter
- Copy of the patient's insurance identification card – both sides
- Copy of the provider's contract with the insurance company, if any
- Copy of the Internal Dispute Resolution Process determination letter

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date



# Privacy Notice on Information Collection

## Request for Assistance Forms

\*\*\* This notice is provided pursuant to the Information Practices Act of 1977 (California Civil Code Section 1798.17) \*\*\*

### Collection and Use of Personal Information

California Insurance Code Sections 12921 and 12921.1, and related statutes and regulations, give the California Department of Insurance (CDI) and the Consumer Services Division the authority to regulate and investigate consumer complaints. The CDI uses your information to address complaints brought to the Department's attention. Information is collected subject to limitations contained in the Information Practices Act of 1977, SAM 5300, et seq., SIMM 5305, et seq., and other applicable state and federal laws.

### Providing Personal Information Is Voluntary

You do not have to provide the personal information requested. However, if you do not wish to provide us the necessary information, we may not be able to investigate your complaint. When providing information or documents, please do not include unrequested personal information, such as Social Security Numbers, Driver's License Numbers, unnecessary health-related information, and credit card or financial information.

### Information Provided to CDI Is Confidential

All information you provide to us during the investigation of your complaint will be treated as a confidential communication under California Insurance Code Section 12919. We will not disclose any information to any person outside CDI, unless otherwise permitted or required by law.

### Possible Disclosure of Personal Information

We may share your personal information with the insurance licensee and in the case of an Independent Medical Review with the Independent Medical Review Organization. We may also share your information with other government or regulatory agencies as permitted or required by law, or pursuant to Memorandum of Understanding.

### Access to Your Information

You have the right to access records containing your personal information which are maintained by CDI. To request access, contact: CDI Privacy Officer, Legal Division, Government Law Bureau, 300 Capitol Mall, Suite 1700, Sacramento, CA 95814, (916) 492-3500.

### Department Privacy Policy

The California Department of Insurance has developed policies regarding the privacy of your information. They may be viewed at [www.insurance.ca.gov/privacy-policy](http://www.insurance.ca.gov/privacy-policy).