

DEPARTMENT OF INSURANCE

CONSUMER SERVICES AND MARKET CONDUCT BRANCH
CONSUMER SERVICES DIVISION
300 SOUTH SPRING STREET, SOUTH TOWER
LOS ANGELES, CA 90013

www.insurance.ca.gov

CSD-002-HRFA

Revised: 05/14/2015



HEALTH REQUEST FOR ASSISTANCE (HRFA)

Name \_\_\_\_\_ Daytime Phone: ( ) \_\_\_\_\_

Address \_\_\_\_\_ Alternate Phone: ( ) \_\_\_\_\_

City/Zip \_\_\_\_\_ Email address: \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_ Insured's Gender [ ] Male [ ] Female

Name of the policyholder if different from your name: \_\_\_\_\_

Type of Insurance: [ ] Health [ ] Dental/Vision [ ] Medicare Supplement [ ] Other \_\_\_\_\_

What is the primary language spoken in your home? \_\_\_\_\_

In order to ensure all Californians have access to health insurance, please identify your race/ethnicity. One or more categories may be selected:

- [ ] American Indian/Alaska Native [ ] Asian
[ ] Black/African American [ ] Hispanic/Latino
[ ] Pacific Islander/Native Hawaiian [ ] White
[ ] Decline to State

Complete name of insurance company involved: \_\_\_\_\_

Policy number: \_\_\_\_\_ Claim number: \_\_\_\_\_

Date(s) of Medical Service(s) Provided (if applicable) \_\_\_\_\_

Insurance Agent (if applicable) \_\_\_\_\_ Agent License Number \_\_\_\_\_

Agent Phone Number: \_\_\_\_\_ Agent Email Address: \_\_\_\_\_

Agent Street Address \_\_\_\_\_ City/State \_\_\_\_\_ / \_\_\_\_\_ Zip \_\_\_\_\_

Have you contacted the company or the agent? Yes [ ] No [ ]

If yes, state the date(s) and person(s) contacted \_\_\_\_\_

Have you reported this to any other governmental agency? Yes [ ] No [ ]

Name of Agency: \_\_\_\_\_

Date Reported: \_\_\_\_\_ Case Number \_\_\_\_\_



RFA

Have you previously written to the Department of Insurance about this matter? Yes  No   
File number (if available) \_\_\_\_\_ Date \_\_\_\_\_

Are you represented by an attorney in this matter? Yes  No

Has a lawsuit been filed? Yes  No

Is the case currently in active litigation? Yes  No  *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 your problem (use additional paper if needed):

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What do you consider to be a fair resolution to your problem?

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In order for us to effectively begin our investigation, please provide any supporting documentation you may have related to this matter along with your *Health Request for Assistance (HRFA)*.

- Copy of insured's insurance identification card – both sides
- Copies of correspondence between you and the insurance company/agent, including all related Explanation of Benefits (EOBs)
- If you wish to give authority to someone to assist you in filing this *Health Request for Assistance (HRFA)*, please complete the *Authorization and Designation of Agent* form.

**PLEASE READ:**

**I understand that a copy of this form and all documentation submitted will be provided to the licensee involved in this Health Request for Assistance.**

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**State of California  
Department of Insurance  
Authorization and Designation of Agent**

- If you want to give someone the authority to assist you in the filing of your complaint please fill in Parts A and B below.
- If you are a parent or legal guardian filing this complaint for a child under the age of 18, you do not need to complete this form.
- If you are filing a complaint for a consumer who cannot complete this form and you have legal authority to act for this consumer, please complete Part B only. Also send a copy of the power of attorney for health care decisions or other legal document that says you can make decisions for the consumer.

**PART A: COMPLAINANT**

I allow the person named below in Part B to assist me in completing a complaint filed with the California Department of Insurance (CDI). I allow the CDI to share my personal information with the person named below in Part B. This may include information about my medical condition(s) and care if applicable and may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want it to end, I must do so in writing.

Name of Complainant (Print) \_\_\_\_\_

Complainant Signature \_\_\_\_\_ Date \_\_\_\_\_

**PART B: PERSON ASSISTING THE COMPLAINANT**

If Applicable, Name of Organization (Please print)

\_\_\_\_\_

Name of Person Assisting (Please print)

\_\_\_\_\_

Signature of Person Assisting \_\_\_\_\_

Address \_\_\_\_\_

Relationship to Complainant

\_\_\_\_\_

Daytime Phone # \_\_\_\_\_ Evening Phone # \_\_\_\_\_

My Power of Attorney for health care decisions or other legal document is attached.

Return the completed form to California Department of Insurance, Consumer Services Division, 300 S. Spring Street, Los Angeles, CA 90013. If you have any questions, the Department can be reached at (800) 927-4357, Outside of California (213) 897-8921.



# 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.

### **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 agencies as required by law.

### **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).