STATE OF CALIFORNIA Ricardo Lara, *Insurance Commissioner*

DEPARTMENT OF INSURANCE
HEALTH CLAIMS BUREAU
300 SOUTH SPRING STREET, SOUTH TOWER
LOS ANGELES, CA 90013
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 ☐ F ☐
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: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Pacific Islander/Native Hawaiian ☐ White ☐ Decline to State	
Complete name of insurance company involved:	
Type of Insurance: Individual Health ☐ Group Health ☐ Dental ☐ Vision ☐ Medicare Supp ☐	
Do you have an existing contract with the insurance company? Yes ☐ (Provide copy) No ☐	
Have you contacted the insurance company and exhausted the Internal Dispute Resolution Process? Yes ☐ (Provide copies of all correspondence) No ☐	
Were services rendered in an in-network facility? Yes ☐ No ☐	
Were services related to emergency care? Yes ☐ No ☐	
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 ☐ No ☐ If yes, provide: Billed Amount $ _____ Paid Amount $_____ Amount in Dispute $_____
Have you reported this to any other governmental agency? Yes ☐ No ☐ Name of agency: _____ File number, if known: _____
Have you previously written to the Department of Insurance about this matter? Yes ☐ No ☐ File number (if available) _____
Are you represented by an attorney in this matter? 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 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.

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.