STATE OF CALIFORNIA — Ricardo Lara, *Insurance Commissioner*

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: 10/01/2024

HEALTH REQUEST FOR ASSISTANCE (HRFA)

Name _____ Daytime Phone: ( ) _____

Address _____ Alternate Phone: ( ) _____

City /Zip _____ Email address: _____

Insured's Date of Birth: _____

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Name of the policyholder if different from your name: _____

Type of Insurance: ☐ Health ☐ Dental/Vision ☐ Medicare Supplement ☐ Other _____

Complete name of insurance company involved: _____

Policy number: _____ Claim number: _____

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 _____

Date(s) of Medical Service(s) Provided (if applicable) _____

What medical treatment(s)/services and/or medication(s) are you asking for? (Please be specific)

Were services related to emergency care? Yes ☐ No ☐

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

Name of Agency: _____

Date Reported: _____ *Case Number* _____

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.*

RFA

Briefly, describe your problem (use additional paper if needed):

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

Statistical Information Only

The following information is used for statistics only in order to ensure all insureds have access to health insurance. Providing this information is optional and will not affect the complaint process in any way.

What is the primary language spoken in your home?			
Gender Identity:			
☐ Male	☐ Female	☐ Transgender Male or Trans Man	☐ Transgender Female or Trans Woman
☐ Non-Binary or Gender non-conforming	☐ Intersex	☐ Gender identity not listed	☐ Prefer not to disclose
Race/Ethnicity:			
☐ American Indian/Alaska Native	☐ Asian	☐ Pacific Islander/Native Hawaiian	
☐ Black/African American	☐ Hispanic/Latino	☐ White	☐ Prefer not to disclose

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 note, this form is required if filing on behalf of an adult child.

PLEASE READ:

I understand that a copy of this form and all documentation submitted will be provided to the licensee involved in this complaint at any time.

_____ (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 Mailing Address _____

Complainant Email Address _____ Phone Number _____

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 # _____ Email Address _____

☐ 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.

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.