STATE OF CALIFORNIA Dave Jones, Insurance Commissioner

DEPARTMENT OF INSURANCE
CLAIMS SERVICES BUREAU
300 SOUTH SPRING STREET, SOUTH TOWER
LOS ANGELES, CA 90013
www.insurance.ca.gov
CCB-025 P
Eff.: 01/03/2011

HEALTH CARE PROVIDER REQUEST FOR ASSISTANCE (HPRFA)

_____ _____
Patient's Name Provider Contact Name (Last, First)

_____ _____
Provider/Facility Name Phone Number

_____
Provider's Address

_____
City Zip

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Providers may submit complaints for services rendered on or after January 1, 2006. Before you file for a case review with the Department of Insurance, you must first exhaust the Dispute Resolution (DR) process with the insurance company. You must allow the insurer up to 60 calendar days to complete their review or send you a written determination, whichever period is shorter. If you submit a complaint to the Department without going through the dispute resolution process first, the Department will not be able to conduct a case review.

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.

1. Complete name of insurance company involved: _____

2. Type of Insurance: Individual Health ☐ Group Health ☐

3. Do you have an existing contract with the insurance company? Yes ☐ (Provide copy) No ☐

4. Primary policyholder's name if different than the patient: _____

   Claim Number: _____ Policy/Certificate/ID Number: _____

   Group Name: _____ Group Number: _____

   Date(s) of Medical Service(s) Provided: _____

   CPT Codes: _____

5. Does the complaint concern the payment of a specific claim? Yes ☐ No ☐

   If yes, provide: Billed Amount $ _____ Paid Amount $_____ Amount in Dispute $_____

6. Have you contacted the insurance company and exhausted the Dispute Resolution Process?
   Yes ☐ (Provide copies of all correspondence) No ☐

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

   Name of agency: _____ File number, if known: _____

8. Have you previously written to the Department of Insurance about this matter?
   Yes ☐ No ☐ File number (if available) _____

9. Is there attorney representation in this matter? Yes ☐ No ☐

10. Has a lawsuit been filed? Yes ☐ No ☐ If yes, our ability to mediate this matter is limited, but we will investigate your inquiry for any regulatory issues. We may 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 law by the insurer that you or your attorney are willing to provide.

11. 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

_____ _____

Provider's Signature Date