Wisconsin Office of the COMMISSIONER OF INSURANCE

125 South Webster Street, P.O. Box 7873 | Madison, WI 53707-7873
p: 608-266-0103 | p: 1-800-236-8517 | f: 608-264-8115
OCINSAComplaints@wisconsin.gov | oci.wi.gov

No Surprises Act Complaint Form

The Office of the Commissioner of Insurance (OCI) helps consumers with insurance problems. Please complete this form as thoroughly as you can. Mailing details are on the last page of this form. We will send a copy of your complaint to the insurance company and/or billing provider. In most cases, they will respond directly to you and tell us what action was taken. Typically, you can expect to hear from the company within about 25 days from the date you send us your complaint. When we receive information from the company or billing provider, we will review all documentation and decide what action we can take. We will notify you of that decision. If you do not get the resolution you want, you may contact a private attorney for advice. If your complaint involved a claim dispute, you could contact your county's small claims court.
Type or print clearly with a black pen.

I. Person Filing the Complaint

1. Your Name		
Business Name (if filing on behalf of a business)		
Mailing Address		
City	State	Zip Code
Email (most correspondence from OCI is sent via email)		
Phone number where we can reach you between 8 am - 4:30 pm		
2. I am filing this complaint as: ☐ Insured ☐ Provider ☐ Other (specify)		

II. Insurance Policy Information

3. Name of Insurance Company (Provide the exact name of the insurance company as it appears on your medical insurance card. Incorrect names will delay the handling of your complaint.)	
4. Name of Policyholder or Insured	
5. Name of Member/Dependent (if different than insured)	
6. Member Number	
7. Type of Insurance ☐ Individual Health Insurance ☐ Group Health Insurance If Group, name of employer:	
8. Date Policy or Certificate was sold	9. State in which Policy or Certificate was sold

III. Billing Provider Information (hospital, facility, clinic, lab, doctor, etc.)

Provide the following information from the bill or statement you received from the provider.

10. Name of billing provider as appears on bill or statement		
11. Mailing address of provider billing department City	State	Zip
12. Billing provider phone	13. Billing provider email	
14. Account number (may be shown as patient or guarantor number)	15. Patient name	

IV. Details of Complaint

16. Check the issue or issues that your complaint pertains to:

- ☐ I have been billed more than expected for one or more of the following types of services:
  - air or ground ambulance
  - assistant surgeon
  - lab/pathology or imaging/radiology sent to an out of network provider
  - services that I believed were in-network
- ☐ I was charged out-of-network rates for emergency services, or I was charged more than expected for emergency services.
- ☐ I received services from a provider shown as in-network in my provider directory, but I have learned that provider is no longer in-network, or I otherwise relied on the provider directory and the information is not accurate.
- ☐ My health plan or provider failed to provide me with reasonably accurate, good faith, advance price estimates or I did not have access to a price comparison tool.
- ☐ Other issue that I believe falls under the consumer protections of the Federal No Surprises Act.

17. Provide a copy of the **billing statement or invoice** for the service in question and any additional information related to your problem **including date/s of service**. Please only include **copies/scans** of important papers (NO ORIGINALS, NO PHOTOS), letters, or other information related to your problem. Include additional pages as necessary.

18. Please indicate how you think your problem should be resolved. Include additional pages as necessary.

19. Have you previously reported this problem to the Centers for Medicare & Medicaid Services (CMS)?

☐ Yes ☐ No

If yes, when and what action was taken? Include additional pages as necessary.

20. Have you previously reported this problem to any other government agency?

☐ Yes ☐ No

If yes, which agency, when, and what action was taken? Include additional pages as necessary.

V. Submission Details

Consent to Release Information

The information I have included above is true and accurate to the best of my knowledge. This information may be forwarded to the insurance company and/or billing provider involved. Any medical information that I have provided may be shared with those parties, if necessary, for the investigation of this matter. I understand that under Wisconsin's Open Records Law all information in my file, including personal and health information, may become a public record once my file is closed. Only actual medical records obtained by OCI directly from a health care provider are confidential under s.146.82, Wis. Stat.

Signature _____ Date _____

To email, fax, or mail the form, use the contact information below. If you have questions, call us at 1-800-236-8517 (within Wisconsin) or 1-608-266-0103 (outside Wisconsin) or send an email.

Email: OCINSAComplaints@wisconsin.gov

Fax: 1-608-264-8115

Mailing Address:
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

For FedEx, UPS, or Overnight Mail use this address:
Office of the Commissioner of Insurance
125 South Webster Street
Madison, WI 53703-3474