www.IllinoisAttorneyGeneral.gov

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Health Care Bureau
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Rev.01/24

YOUR INFORMATION

Your Name: Mr. ☐ Mrs. ☐ Ms. ☐ _____

Street Address:_____

City:_____ State:_____ Zip Code:_____ County:_____

Daytime Phone: (_____) _____ Evening Phone: (_____) _____

Email (Optional):_____

PATIENT'S INFORMATION

Patient's Name: Mr. ☐ Mrs. ☐ Ms. ☐ _____

Street Address:_____

City:_____ State:_____ Zip Code:_____ County:_____

Daytime Phone: (_____) _____ Date of Birth: _____

Senior Citizen: Yes ☐ No ☐

YOUR COMPLAINT IS AGAINST (RESPONDENT)

Name:_____

Contact Person:_____ Phone: (_____) _____

Street Address:_____

City:_____ State:_____ Zip Code:_____ County:_____

Account No.:_____ Date of Service:_____

Is the claim in collections? Yes ☐ No ☐ If yes, please provide:

Name:_____ Phone: (_____) _____

Account No.:_____ Contact Person:_____

Total Cost:_____ Amount Paid:_____ Money Owed:_____

By Whom (i.e., Ins. Co.):_____

YOUR COMPLAINT IS AGAINST (RESPONDENT) – Continued from Page 1

How Paid (e.g., cash, check, credit card, etc.):_____

Have you complained to the company/individual? Yes ☐ No ☐ If yes, please provide:

Complained by: Mail ☐ Phone ☐ In Person ☐ Facsimile (Fax) ☐ Other ☐ _____

Person Contacted:_____

Job Title:_____ Phone: (_____) _____

Nature of Response:_____ Date of Response:_____

Did you sign a contract? Yes ☐ No ☐ If yes, please attach a copy.

Was the product/service advertised? Yes ☐ No ☐ If yes, please attach a copy, if available.

Who referred you to this office? _____

Is court action pending? Yes ☐ No ☐

Has this matter been submitted to another agency/attorney? Yes ☐ No ☐

If yes, please provide:

Name:_____ Phone: (_____) _____

PRIMARY INSURANCE INFORMATION AT THE TIME OF SERVICE

Insurance Name:_____

Contact Name:_____ Phone: (_____) _____

Street Address:_____

City:_____ State:_____ Zip Code:_____ County:_____

Type of Plan: HMO ☐ PPO ☐ Dental ☐ Medicare ☐

Supplemental ☐ Other ☐ _____

Employer Name:_____ Phone: (_____) _____

Self-Insured? Yes ☐ No ☐

Employer Street Address:_____

City:_____ State:_____ Zip Code:_____ County:_____

Policy Holder:_____ Group:_____

ID#:_____

SECONDARY OR SUPPLEMENTAL INSURANCE AT THE TIME OF SERVICE

Insurance Name:_____

Contact Name:_____ Phone: (_____) _____

Street Address:_____

City:_____ State:_____ Zip Code:_____ County:_____

Type of Plan: HMO ☐ PPO ☐ Dental ☐ Medicare ☐

Supplemental ☐ Other ☐ _____

Policy Holder:_____ Group:_____

ID#:_____

A DESCRIPTION OF YOUR PROBLEM

Please use additional paper, if necessary. Also, attach copies of all documents related to your complaint. PLEASE DO NOT SEND ORIGINALS.

_____

_____

_____

_____

_____

TYPE OF RESOLUTION/RELIEF YOU ARE SEEKING

For example: Exchange, repair, money back, product delivery, etc.

_____

In filing this complaint, I understand that the Illinois Attorney General is not a private attorney, but rather enforces laws designed to protect the public from misleading or unlawful business practices. I also understand that if I have any questions concerning my legal rights or responsibilities, I should contact a private attorney. I have no objection to the contents of this complaint being forwarded to the business or the person the complaint is directed against, unless the box below is checked. The above complaint is true and accurate to the best of my knowledge.

_____ _____

Signature Date

☐ Check here if you only want to notify our office of your concerns and do not want a mediation process initiated.

We recommend that you print an additional copy of the completed form for your records.

Print Form

Reset Form