TEXAS DEPARTMENT OF INSURANCE
Compliance Division - Consumer Protection (111-1A)
333 Guadalupe, Austin, Texas 78701 ✯ PO Box 149091, Austin, Texas 78714-9091
(800) 252-3439 | F: (512) 490-1007 | TDI.texas.gov | @TexasTDI

Date

Health Insurance Mediation Complaint Form

1. Use this form to file a complaint about the actions of an insurance company during the health insurance mediation process. For other insurance complaints about companies, agents, or adjusters, file a complaint using our Online Complaint Portal at www.tdi.texas.gov/consumer/complfrm.html or by calling the Consumer Help Line at 1-800-252-3439.
2. Fill out these forms and return them: (a) by email at ConsumerProtection@tdi.texas.gov, or (b) by using the fax number or address listed at the top of this form.

Person who got the care (patient)

Name (first, middle, last)	Daytime phone number	Email address (optional)
Mailing address	City, state, ZIP code	

Attorney or representative Information (if you have one)

Name (first, middle, last)	Phone number
Mailing address	City, state, ZIP code

Insurer or health plan administrator

Name	Phone number
Mailing address	City, state, ZIP code
Policyholder name, if different from the person who got the care	Group policy number
Enrollee (person who got the care) or subscriber number	Claim number assigned by insurer or administrator

Doctor or health care provider who billed you and is not in your health plan's network

Name (first and last name)	Phone number
Mailing address	City, state, ZIP code
Dates of service on bill	Billed amount (don't include copays, deductibles, coinsurance, or amounts paid directly to you by an insurer or administrator)

Place where you got the care

Name	Phone number
Mailing address	City, state, ZIP code

Tell us about your claim and your complaint

If you need more space, please attach additional pages.

Note: A copy of this complaint will be sent to the insurance company involved.

(Please type your name on all signature lines in this document if you're filling out electronically.)

Person who got the care or legal representative

Date

Approval to share your health information and other private facts

Authorization to disclose information

You filled out a form asking for help with a surprise bill you got from a health care provider. To help you, we might need to share information you gave us. Some of the information we need to share might be: (1) about your health, and (2) facts that ID you, for example, your address and birth date. By law, we need your approval to share this information.

► Who can get and use your information?

By signing this form, you allow us to share your information with those involved in your case. This can include all of the people and organizations listed on the forms you filled out asking for help and the following and their representatives:

- The hospital, clinic, emergency care provider, or other provider where you got services or supplies.
- Your health benefit plan's insurer or administrator.
- The State Office of Administrative Hearings and anyone they ask to work on your case.

► What can be shared?

By signing this form, you allow TDI to share: (1) the information you filled out on the form asking for help, (2) your health information, and (3) other private facts.

To allow us to share the following information, you must sign or type your name next to each item:

_____ Mental health records (doesn't include psychotherapy notes)

_____ Genetic information and test results

_____ Drug, alcohol, or substance abuse records

_____ HIV/AIDS test results and treatment

_____ Motor vehicle records

► When will this approval end?

This approval will end if:

- The person who asked for our help turns 18 years old (the complaint was filed for a person age 17 or younger).
- The person who asked for our help tells us they no longer want our help.
- The person who asked for our help dies.
- The law about how we can help with surprise bills ends. (The law and rules can be found in Texas Insurance Code 1467).
- You enter an end date for this agreement here (this is optional): _____
  Month (MM) / Day (DD) / Year (YYYY)

► What are your rights?

You have the right to see and get facts we have about you: If you want to get information we have about you, you must ask us in writing. You might need to pay to get a copy of this information. You can send your letter or email one of these ways:

Email: OpenRecords@tdi.texas.gov
Fax: 512-490-1021
In person: 333 Guadalupe, Austin, Texas 78701

Mail: Public Information Coordinator, Texas Department of Insurance
PO Box 149104 (mail code 110-1C)
Austin, Texas 78714-9104

You have the right to ask that we fix information we have about you that is wrong: If you want to ask that we fix information we have about you that is wrong, you must ask us in writing. The letter or email must have: (1) your name and mailing address, (2) your phone number, (3) details about what needs to be fixed, and (4) the reason or proof showing why the information is wrong. You can send your letter or email one of these ways:

Email: RecordCorrections@tdi.texas.gov
Fax: 512-490-1025
In person: 333 Guadalupe, Austin, Texas 78701

Mail: Record Correction Request, Texas Department of Insurance
PO Box 149104 (mail code 113-1C)
Austin, Texas 78714-9104

You have the right to cancel or change this approval: If you want to cancel this approval or change who can get your health information and other private facts, you must ask us in writing. You can email ConsumerProtection@tdi.texas.gov or send a letter to the address or fax number at the top of this form. Please note that any actions taken and information shared before we get your letter or email are covered by this signed agreement.

► Sign below to show you:

- agree to allow TDI to share my health information and other private facts as listed on this form.
- know TDI might share my information with organizations that are covered in Texas Health and Safety Code section 181.154(c).
- know TDI is not responsible for health information or private facts shared by the people or other organizations listed on this form.

Person who has the complaint or their authorized representative — Date

If an authorized representative signs this form:

1. Print their name: _____
2. How are they related to the person with the complaint:

☐ Parent ☐ Guardian ☐ Other please list: _____

If the complaint is on behalf of a person who is age 17 or younger, that person must sign here to allow us to share facts about: (1) birth control / reproductive care; (2) sexually transmitted diseases; (3) drug, alcohol, or substance abuse; and (4) mental health treatment.

Person who is age 17 or younger — Date