Health Maintenance Organization (HMO) Complaint

Data Practices Notice

1. The **Minnesota Government Data Practices Act** requires that we provide you with the following information:
   a. the purpose and intended use of the data you provide is to help the Minnesota Department of Health investigate and take action on your complaint.
   b. you are not legally required to provide any data to the department and you may refuse to provide any data. However, if you do not provide the requested data, the department may not be able to fully investigate and take action on your complaint.
   c. any data you provide may be used in action that the department brings against an HMO.
   d. the data you provide may be disclosed to certain persons or entities including individual staff members within the department whose job requires them to handle the complaint material, outside experts, the Office of the Attorney General, and other agencies that have legal authorization to obtain the data.
2. As part of your complaint, the department may find it helpful to send a copy of your complaint to your HMO. Unless you tell us not to, a copy of your complaint may be sent to your HMO.
   ☐ **Do not send a copy of my complaint to my HMO.**
3. Please be advised that after our investigation is closed, an individual who is the subject of the complaint has the right to see the complaint file. If you are filing information on behalf of another person, the information you provide will become part of the complaint file and may be seen by the person that is the subject of the complaint once it is closed.
4. If it is determined that the complaint against your health plan does not fall under the jurisdiction of MDH we may forward it to the appropriate state agency for follow up (Commerce, Human Services or Minnesota Management and Budget). Please indicate if you authorize MDH to share your complaint with another state agency.
   ☐**I authorize MDH to forward my complaint to the appropriate state agency**
   ☐**I DO NOT authorize MDH to forward my complaint to the appropriate state agency**

Minnesota Department of Health
Managed Care Section
PO Box 64975
St. Paul, MN 55164-0882
651-201-5100 or 1-800-657-3916
health.mcs@state.mn.us
www.health.state.mn.us/facilities/insurance/managedcare/complaint/index.html

9/24/2024

To obtain this information in a different format, call: 651-201-5100.

DEPARTMENT OF HEALTH

HMO Complaint Form

To assist you in addressing your complaint, you must complete this form including the Consent to Release. Submit the completed form to Minnesota Department of Health, Managed Care Section, P.O. Box 64975 St. Paul, Minnesota 55164-64975 or email it to health.mcs@state.mn.us. Based on the information you supply; we will do our best to help you resolve your complaint.

Person submitting complaint		
Name	Daytime Phone	Alternate Phone
Street Address		
City	State	Zip
Name of enrollee for whom you are filing this complaint (if you are not filing for yourself).		Relationship to enrollee
Email Address of person submitting complaint:		
Is there a family member you would like interviewed as part of this investigation? ☐ yes ☐ no **If yes, please provide:**		
Name	Relationship to you	Phone Number
Name of HMO		
☐ Allina Health & Aetna Health Plan ☐ Blue Plus ☐ HealthPartners ☐ Hennepin Health ☐ Humana of WI	☐ Medica Health Plan ☐ PrimeWest ☐ Quartz ☐ Sanford Health Plan of MN ☐ South Country Health Alliance	☐ UCare ☐ United HealthCare of IL ☐ Other: _____
Type of Coverage		
☐Group (Employer) ☐ Individual (MNsure) ☐ PMAP ☐ MinnesotaCare ☐ Medicare ☐ Other:_____		
Enrollee Information		
Enrollee/Membership Number		Date of Birth

Incident Information	
Name of Enrollee's Primary Clinic/Primary Care Physician	Date(s) of Incident
What would you like to see happen to resolve this complaint?	
Narrative description of your complaint: In the space below, tell us what happened including when and where it happened and who was involved. If possible, include the full names of any involved individuals from the HMO, the clinic, the hospital or any other provider. If possible, attach copies (do not send originals) of any relevant documents such as referrals, denials, prior authorizations, bills, explanation of benefits, and written correspondence. Attach additional sheets if necessary.	

DEPARTMENT OF HEALTH

Consent to Release

It may be necessary to obtain copies of protected health information for MDH to fully investigate your complaint. We must have the **patient's** signed permission to obtain information. We have provided a Consent to Release form which will be used to obtain protected health information from your providers. The **patient** should sign and date the enclosed Consent to Release and return it with the HMO Complaint.

Patient Information	
Name	Date of Birth
HMO	HMO ID Number

The list of providers may include clinics, physicians, hospitals, pharmacies, and any other provider that may have protected health information (PHI) relevant to your complaint. For each provider listed, please indicate the dates of service, or time period, that is relevant to your complaint.

Provider(s) Use back for additional Providers *Example: Hospital X, Clinic X, Dr X*	**Date(s) of Service** *Example: July 1 – August, 2008*

By signing this form, I give permission to my HMO and to the care provider(s) listed above to provide a copy of my PHI to the Minnesota Department of Health (MDH), or to allow them to be inspected and/or copies to be provided to the MDH. I give permission to my HMO and the provider(s) listed above to testify without limitations and without liability as to any and all findings and/or treatment referred to in them.

Patient/Guardian Signature	Date
Relationship to Patient (if signed by guardian)	Reason Patient unable to sign

This release takes effect on the date I sign and is good for 6 months or until the conclusion of the MDH investigation including any legal actions taken by MDH, whichever comes first. I may cancel this consent at any time by notifying the provider(s) listed above in writing. My cancellation will not have any effect on information released before the provider(s) received my written notice of cancellation.