Health Insurance Balance Billing Complaint Form

State Corporation Commission Bureau of Insurance

Toll-free: 1-877-310-6560 | Fax: (804) 371-9944

scc.virginia.gov/pages/Insurance

According to Virginia law, an out-of-network provider can no longer balance bill or collect more than a covered person's in-network cost-sharing amounts **for dates of service on and after January 1, 2021,** related to (1) emergency services or (2) non-emergency surgical or ancillary services like lab or professional services, such as anesthesiology, pathology, radiology, and hospitalist services at an in-network facility.

In addition to the protections provided by Virginia's Balance Billing law, the federal No Surprises Act (NSA) provides protections for balance billing including but not limited to air ambulance services, post-stabilization services, and coverage that does not fall under Virginia law for dates of service on or after January 1, 2022. Please refer to scc.virginia.gov/pages/Balance-Billing-Protection for more NSA information.

To file a complaint concerning balance billing, please complete this form. Additional information may be required.

I am filing a complaint against a(n): *If you are complaining against more than one entity, please complete a separate form for each.*

☐ Insurance Company ☐ Third-party Administrator ☐ Health Care Professional/Medical Provider

☐ Facility (hospital, ambulatory surgical center, or other health care facility)

Business Name: ______

Address: ______

City: ______ State: ______ Zip Code: ______

Business Telephone Number: (____) ______ Website: ______

Please check all that apply:

☐ **Emergency services**
You received services from an out-of-network hospital, or an out-of-network doctor or other medical provider at a hospital.

☐ **Non-emergency surgical or ancillary services**
You received services at an in-network hospital or facility for professional services, including surgery, anesthesiology, pathology, radiology, or hospitalist services and laboratory services, that exceeds your in-network cost-sharing amount.

Complainant Contact Information:

Name: Mr./Ms. ______

Address: ______

City: ______ State: ______ Zip Code: ______

Preferred phone number: (___) ______ Email: ______

Insured Contact Information (if different from complainant):

Name: Mr./Ms. ______ Date of Birth: ______

Address: ______

City: ______ State: ______ Zip Code: ______

Preferred phone number: (____) ______ Email: ______

Policyholder/Policy Identification Information:

Source of Insurance Coverage: ☐ Individual ☐ Group

Name of Insurance Company:______________________________

If Employer-sponsored coverage provide the name of the Employer:______________________________

Policy #:______________ ID#: ______________ Certificate #:______________

Business Address:______________________________

City:______________________________ State: ______________ Zip Code:______

Business phone: (___) ______________ Fax Number: (___) ______________

Describe your complaint:

NOTE: For Medical Providers, Facilities, Insurance Companies, or Third-party Administrators filing this complaint, the below authorizations are not necessary.

Insured Authorization:

I have enclosed copies of correspondence related to this complaint and authorize the BOI to send a copy of this form and any or all enclosed documents to the party complained against, other regulated entities, or the appropriate state or federal agency. I authorize the release of all medical records related to this complaint and authorize release of these medical records to the BOI, insurance company and appropriate federal agency. I also authorize the BOI to obtain any information required to assist me. If this complaint appears to fall under the protections of the federal NSA external review process administered by U. S. Department of Health and Human Services, I authorize the BOI to file this form and related documents for that process.

Signature of Insured (if 18 or over) or parent or legal guardian (if Insured is under 18)

(Type name to sign)
______________________________ **Date:**______________

Representative Authorization:

I,______________________________,(Insured, parent or legal guardian), authorize the BOI to: (i) discuss this complaint with, and (ii) share medical information related to this complaint with______________________________ (Authorized Representative). **Note:** This authorization is not necessary if the Representative is the parent or legal guardian of an Insured is under 18 years of age, or if the Insured is deceased or incapacitated.

Signature of Insured (if 18 or over) or parent or legal guardian (if Insured is under 18)

(Type name to sign)
______________________________ **Date:**______________

State Corporation Commission, Bureau of Insurance, Life and Health Division, P.O. Box 1157, Richmond, VA 23218