File Number: _____ (office use only)

PLEASE DO NOT STAPLE

NORTH CAROLINA DEPARTMENT OF INSURANCE
CONSUMER SERVICES DIVISION • 855-408-1212

REQUEST FOR ASSISTANCE

PLEASE PRINT

An online version of this form is available at www.ncdoi.com/consumer

PERSONAL INFORMATION

YOUR NAME (LAST, FIRST, MI)

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.

ADDRESS	CITY	STATE	ZIP

EMAIL ADDRESS	HOME PHONE	WORK PHONE	MOBILE PHONE

RELATIONSHIP TO INSURED

☐ Self ☐ Spouse ☐ Medical Provider ☐ Attorney ☐ Beneficiary ☐ Other Driver ☐ Passenger ☐ Other:

INSURANCE INFORMATION

NAME OF INSURED (LAST, FIRST, MI)	POLICY OR GROUP NO.
INSURANCE COMPANY	CLAIM OR CERTIFICATE NO.

AGENT	ADJUSTER	DATE OF LOSS
		/ /

TYPE OF INSURANCE	IF LIFE OR HEALTH POLICY, IN WHICH STATE WAS THE POLICY OR CERTIFICATE PURCHASED?
☐ Life ☐ Health ☐ Auto ☐ Homeowners ☐ Other	

ARE YOU REPRESENTED BY AN ATTORNEY IN THIS MATTER?

☐ Yes ☐ No (If Yes, we must have your attorney's consent in writing to be able to assist you.)

ARE YOU COVERED UNDER THE N.C. STATE HEALTH PLAN?	ARE YOU COVERED UNDER A SELF-FUNDED EMPLOYER PLAN?	ARE YOU REQUESTING ASSISTANCE WITH FILING A MEDICAL APPEAL FOR DENIED MEDICAL SERVICES?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

DETAILS OF COMPLAINT (PLEASE ATTACH COPIES OF DOCUMENTS RELATING TO THIS MATTER)

The North Carolina Department of Insurance is authorized to send a copy of this document(s) to any company or agency involved. I authorize the release of all relevant information to the North Carolina Department of Insurance for its use in the review of this matter. I understand that consumer complaints become public record in accordance with applicable laws.

SIGNATURE _____ DATE _____

The North Carolina Department provides a service to consumers who have been denied medical services by their health insurance company. The staff will assist you with constructing your appeal and submitting it to the insurance company. In order to assist you with this, it is necessary for us to obtain some additional information as well as your written consent to obtain your medical records if necessary.

PROVIDER OR DOCTOR(S) WHO IS RECOMMENDING THE SERVICES:			
NAME	PHONE NUMBER		
ADDRESS	CITY	STATE	ZIP

MEDICAL APPEALS: RELEASE OF YOUR MEDICAL INFORMATION

The undersigned has requested assistance from the North Carolina Department of Insurance (Department) with a medical appeal. In order to facilitate this assistance, the undersigned authorizes the Department to obtain from the health plan or health insurance issuer involved, and their sub-contractors, all information relating to the matter in question, including, but not limited to, the individual's files and medical record information. Payment of fees, if any, for obtaining these records is the sole responsibility of the undersigned. The undersigned may revoke this authorization at any time. Revocation of this authorization will be effective upon receipt, but will not affect actions already taken on the basis of this authorization. **As provided by NCGS 58-2-105, all patient medical records in the possession of the Department shall be confidential.**

PRINTED NAME _____ SIGNATURE _____ DATE _____

SERVICES PROVIDED BY THE NORTH CAROLINA DEPARTMENT OF INSURANCE

- Education on your insurance policy
- Provide case management of your complaint: Review your circumstances and require the insurance company to take corrective action if the company's position does not comply with applicable requirements.
- Department staff will assist you with your complaint if you are covered under the State Health Plan or a self-funded employer plan; however, the Department does not regulate these entities.
- Recommend other courses of action that you can take if we don't have the regulatory authority to resolve the issue. We cannot make legal determinations or act as your legal representation. In fact, if you are represented by an attorney, we cannot intervene on your behalf unless we have your attorney's permission.
- The Department of Insurance does not make determinations as to who was negligent or at fault in an accident. In addition, we cannot determine the value of a claim or the amount of money due to you or to establish what the facts are in a disagreement between you and your insurance company or any other party.
- **FOR PROVIDER COMPLAINTS ONLY: DO NOT INCLUDE ANY PATIENT IDENTIFYING INFORMATION ON THIS FORM. HOWEVER, SUCH INFORMATION MAY APPEAR ON DOCUMENTATION THAT YOU ATTACH TO THIS FORM.**

PLEASE LET US KNOW HOW YOU HEARD ABOUT US

☐ State Fair ☐ NCDOI Speaker ☐ Insurance Company/Agent ☐ Radio ☐ Newspaper ☐ Internet
☐ Other (Please specify):

North Carolina
DEPARTMENT OF INSURANCE
Mike Causey, Commissioner

N.C. Department of Insurance
Consumer Services Division
1201 Mail Service Center
Raleigh, NC 27699-1201

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