Other Sources:

Self-Funded Health Benefit Plans and Union Health and Welfare Plans:

United States Department of Labor Employee Benefits Security Administration
1885 Dixie Highway, Ste. 210
Fort Wright, KY 41011
859-578-4680 or 866-444-3272
www.dol.gov/ebsa

COBRA (Consolidated Omnibus Budget Reconciliation Act):

United States Department of Labor Pension and Welfare Benefits
200 Constitution Avenue, NW, Room N-5658
Washington, DC 20210
866-444-3272
www.dol.gov/cobra

Medicare:

800-MEDICARE or 800-633-4227
www.medicare.gov

Workers' Compensation Claims:

Department of Licensing and Regulatory Affairs: Workers' Compensation Agency
P.O. Box 30016
Lansing, MI 48909
888-396-5041
www.michigan.gov/wca

Affordable Care Act:

www.healthcare.gov

DIFS DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Michigan Department of Insurance and Financial Services

Visit DIFS online at: www.michigan.gov/DIFS or call DIFS toll-free at 877-999-6442

Department of Insurance and Financial Services
Office of Consumer Services
P.O. Box 30220
Lansing, MI 48909-7720

DIFS DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Guide to Resolving Health Insurance Problems

State of Michigan
Rick Snyder, Governor

DIFS DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

When You Have a Dispute With a Health Carrier or Agent:

Use the attached form to file a complaint with the Department of Insurance and Financial Services (DIFS) if you are in a dispute with a health carrier or insurance agent and you disagree with the outcome of a health claim, determination of your eligibility for health coverage, or any other issue involving your health coverage.

Read further to find out how DIFS can help and what your appeal rights are with regard to health claim disputes.

First Contact the Company or Agent:

If you disagree with your health carrier or agent, first contact the company and/or agent:

- Speak with a company representative to try to find a solution.
- Explain the problem in a calm, courteous manner.
- Provide dates, amounts, and as many related facts as you can.

If you still do not agree with the company or agent's position, ask them to provide a written response. Ask them to list the specific rules or language in the policy that allow them to deny or exclude coverage, or to include copies of documents you signed when you applied for insurance to support their actions.

How DIFS Can Help:

If you are still dissatisfied after contacting the company or the agent, you may wish to contact DIFS, Office of Consumer Services, to ask questions or to file a written complaint by completion of this form.

When you file a complaint, Consumer Services acts as a link between you and the company or agent. We try to resolve the complaint and see that your questions are answered. Your complaint is based on the documents you submit. Be sure to include all pertinent information. Include:

- Name of the health carrier and/or agent involved in the dispute.
- Policy and claim numbers and name of employer for group plans.
- Details of any previous contact regarding the matter.
- Copies of documents that help verify or explain the problem.

Always send copies. Please do not send original documents.

When we receive your complaint we will review your concerns and determine if the complaint involves a claim denial or other issue concerning your health carrier.

If Your Complaint Involves a Health Coverage Claim Denial:

Internal Grievance Process

You are eligible to appeal through the health carrier's Internal Grievance Process if your complaint involves an adverse determination. An adverse determination can be a denial of a claim, discontinuance of coverage for a health care service or refusal to provide authorization for a health care service.

Each health carrier must establish an Internal Grievance Process to have your complaint reviewed. The grievance process is initiated by submitting a written grievance to your health carrier.

If DIFS receives your complaint regarding an adverse determination, we will forward it to the health carrier and ask that it begin the Internal Grievance Process and provide our office with a copy of its final decision.

As part of the Internal Grievance Process, your health carrier must give you the right to appear before the board of directors or designated committee or the right to a managerial-level conference to complete the grievance.

The health carrier must notify you of its final determination in writing and advise you of your right to an External Review pursuant to the Patient's Right to Independent Review Act (PRIRA) if you disagree with their determination.

The health carrier must complete all steps of the Internal Grievance Process within 30 calendar days after a grievance is submitted for pre-service claims and 60 calendar days after a grievance is submitted for post-service claims. The health carrier can request an additional 10 business days if the insurer has not received requested medical information from a health care facility or doctor.

External Review Process
If you still disagree with the insurer's final decision, you can request an External Review through DIFS pursuant to PRIRA. Additional External Review appeal information and the External Review request form is available on our website at www.michigan.gov/difs

If Your Complaint Involves Other Health Coverage Issues:

For issues other than those involving an adverse determination, we will open a complaint file and send you a notice that includes the file number we assigned to your case. We forward your complaint to the health carrier and ask that it respond to DIFS. We will review the health carrier's response to ensure that their position and actions:

- Comply with the policy language.
- Comply with Michigan insurance laws, rules, or directives of the Director.
- Address the issues in your complaint, and is reasonable in light of approved and accepted business practices.

When our review is complete, we will provide you with a response detailing our findings and explain the reason for the outcome pursuant to the policy language and pertinent laws.

If you have questions, disagree with our findings, or have additional information that was not included with your original complaint, and feel it might alter the decision, you may submit the information to us for further review.

Please understand that we strive to resolve all complaints. However, we may not be able to provide the exact results you desire, as we can only resolve disputes based on the information provided and our authority under Michigan law. However, we hope that through our complaint process you are able to gain an understanding of the situation and the policy language and laws that apply.

While we strive to give prompt, quality service, a resolution may not occur immediately. Thank you for your patience during the complaint process.

What DIFS Cannot Do:

Our authority is limited to the companies and agents DIFS licenses. We cannot help resolve disputes with entities we do not license. Self-funded health care plans and union health and welfare plans are generally not under the authority of DIFS. However, DIFS has authority over the administrators of these plans. DIFS has no authority over Medicare or Workers' Compensation claim issues. Helpful contact information is included at the end of this brochure.

Because DIFS regulates the business of insurance transacted in Michigan,our authority pertains to contracts issued in Michigan. Complaints involving out-of-state health care plans should, in most cases, be pursued with the state insurance regulatory agency where the health care plan was issued or delivered. This includes Blue Cross Blue Shield plans from other states.

Provider Complaints:

DIFS generally only accepts complaints from parties involved in the contract, such as the insured, policyholder, or certificate holder. Because a health care provider is not a party to the health care contract, we generally do not accept complaints from providers.

DIFS will pursue complaints from providers acting as the authorized representative of a patient covered by a Michigan licensed health carrier; however, written authorization from the patient or their legal representative must be included with the complaint.

Providers occasionally have problems with receiving timely payment for submitted claims without any errors or other issues, often referred to as "clean claims." Public Act 316 of 2002 was enacted to afford provisions in handling untimely clean claim payments.

A health professional, health facility, home health care provider, durable medical equipment provider, or health plan alleging that a timely processing or payment procedure has been violated may file a complaint with DIFS on Form FIS 0284 and has a right to a determination of the matter by the Director or his or her designee.

Information regarding this process and the form are available on the DIFS website at www.michigan.gov/difs.

FIS 2257 (8/16) Department of Insurance and Financial Services

Health Insurance Complaint Form

Michigan law, including PA 218 of 1956 and PA 350 of 1980, as amended, authorizes the review of consumer complaints involving insurance and similar products. Completion of this form is voluntary and helps us review your complaint.

My Name	Name of Health Carrier May also be an HMO or other company *Please include a copy of the front and back of insurance card
Address	Name of AGENT or AGENCY (if applicable)
City / State / Zip Code	Name of INSURED person on insurance card
My Email Address	Date of healthcare service
Daytime phone number ( ) / Alternate phone number ( )	**Type of Plan** ❑ Individual plan Policy # _____ ❑ Group Plan Name of group/employer _____ Group Contract # _____

Type of coverage my complaint is about:

❑ Health Insurance ❑ COBRA
❑ HMO ❑ Medicare Supplement
❑ BCBS of Michigan ❑ Medicare Advantage
❑ Vision ❑ Medicare RX Part D
❑ Dental ❑ Other_____

Reason for complaint: (Check all that apply)

❑ Claims Issue ❑ Dependent Coverage ❑ Misrepresentation of Coverage
❑ Rate Issue ❑ Coverage for Health Service ❑ Refusal to Insure
❑ Premium Billing ❑ Cancellation ❑ Other _____
❑ Customer Service ❑ Pre-Existing Condition

Please list events in the order they happened. Attach additional pages if needed. If possible please use letter size paper (8 ½ x 11") for all attachments.

Details of my complaint:

Documentation relating to your complaint is important. This information helps us to understand details of your complaint.

*Please attach copies of letters or other documents that will help us review your complaint. This includes your **insurance cards**, bills, receipts, claim documents or other items that relate to your complaint.*

Always send copies. Never send original documents.

Desired outcome:

Please mail your complaint to:
DIFS – Office of Consumer Services
P.O. Box 30220
Lansing, MI 48909-7720

Or fax to: 517-284-8837
Or Email to:difs-hicap@michigan.gov

I authorize the Department of Insurance and Financial Services (DIFS) to review and release any information to any company, agency or licensee involved in this matter. I authorize the health carrier to release all records (including protected health information) relating to this complaint to DIFS in order to resolve this complaint. I represent that I have the proper authority to execute this release.

Signature Date signed