GOVERNMENT OF THE UNITED STATES VIRGIN ISLANDS
OFFICE OF THE LIEUTENANT GOVERNOR
DIVISION OF BANKING AND INSURANCE

CONSUMER ASSISTANCE PROGRAM
COMPLAINT FORM

Complaint No.: ________________

Date Opened: _________________

Date Resolved/Closed: _______________

COMPLAINANT:

Insured/Provider: ____

Mailing Address: ____

Telephone No.: (_____) _______________ (Home) (_____)________________(Work)

(_____) ________________(Other) E-Mail:___________________________

Gender: ❑Male ❑ Female Date of Birth (mm/dd/yyyy): _______________________

Language: ❑ English ❑ Spanish ❑ Other ____________

Status: ❑ Insured ❑Uninsured

Insurer: __________________________________ Policy Number: _______________

STATUS OF COMPLAINANT:

❑ INSURED ❑PROVIDER ❑EMPLOYER ❑BROKER ❑AGENT ❑OTHER

COMPLAINT AGAINST:

❑AGENT ❑BROKER ❑PROVIDER ❑EMPLOYER/ADMINISTRATOR X INSURANCE COMPANY ❑OTHER

Indicate Individual's/Company's Name: ____

Address: ____

Telephone No.: ______________________ Facsimile No.: ___________________

E-Mail: ____

TYPE OF COVERAGE:

❑AUTOMOBILE BODILY INJURY ❑INDIVIDUAL HEALTH ❑GROUP HEALTH

❑OTHER _____________

REASON FOR COMPLAINT:

❑ PREMIUM RATES ❑ REFUSAL TO INSURE ❑ ACCESS/COVERAGE

❑ CANCELLATION/RENEWAL/RECISSION ❑ AGENT HANDLING

❑ REIMBURSEMENT CHALLENGES ❑CARE IS EXPIREMENTAL/INVESTIGATIONAL

❑ MISLEADING ADVERTISING ❑ DENIAL OF CLAIM/NON PAYMENT

❑ CLAIM HANDLING DELAYS ❑UNSATISFACTORY SETTLEMENT

❑ PREEXISTING CONDITION ❑ NOT ELIGIBLE FOR HEALTH PLAN/BENEFITS

❑CARE IS NOT MEDICALLY NECESSARY ❑QUALITY OF SERVICE

❑ MISREPRESENTATION ❑ OTHER: _______________

SUMMARY / REASON FOR COMPLAINT:

____

____

____

____

____

____

____

____

____

____

____

EXAMINER'S FINDINGS:

____

____

____

____

____

____

____

____

____

____

____

____

____

_____________________ _____________________

Signature **Date**

Hearing Requested By: ____________________ Hearing Date: ___________________

Notice of Penalty: _____________________ Penalty Imposed: ___________________

Court Action: _________________________ Date: _____________________________

Kongens Gade No. 5049, Charlotte Amalie, St. Thomas VI 00802 • Tel: (340) 774-7166 • Fax: (340) 774-9458
1131 King Street, Suite 101, Christiansted, VI 00820 • Tel: (340) 773-6459 • Fax: (340) 719-3801

PROVIDE/ATTACH ANY DOCUMENTATION THAT IS IMPORTANT OR PERTAINS TO THIS COMPLAINT SUCH AS THE DENIAL FROM YOUR INSURER OR LETTERS FROM YOUR TREATING PHYSICIAN.

IMPORTANT: Consent Form for Consumer Assistance Program to assist me with my appeal/complaint.

The undersigned individual has requested assistance from the Division of Banking and Insurance's, Consumer Assistance Program as provided pursuant to Sec. 2793 (Health Insurance Consumer Information) Part C of the Public Health Service Act (300gg-93) and consents to the assistance by the Consumer Assistance Program(CAP)and its agents or employees. The undersigned acknowledges that the information and assistance provided by CAP does not constitute legal representation and that CAP may not serve as the undersigned's authorized representative in any hearing or in any other capacity.
The undersigned acknowledges that there shall be no liability on the part of, and no cause of action of any nature shall arise against, CAP or its agents or employees, the Division of Banking and Insurance or its agents or employees, or the Commissioner or the Commissioner's representatives for any action taken by them in good faith in the performance of their powers and duties.

________________________________ (Print) ______________________________ (Sign)

______________________________ (Date)

IMPORTANT: Release of your medical information.

The undersigned individual has requested assistance from our Consumer Assistance Program, under the office of the Lieutenant Governor, Division of Banking and Insurance. In order to facilitate this assistance, the undersigned authorizes Consumer Assistance Program 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 responsibility of the undersigned. All patient medical records in the possession of CAP shall be confidential.
This authorization will automatically expire upon final resolution of the matter giving rise to the undersigned's request for CAP assistance. 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.

______________________________ (Print) _____________________________ (Sign)

_______________________ (Date)