

## **Arkansas Insurance Department**

## **HEALTH CARE PROVIDER COMPLAINT FORM**

1 HEALTH CARE PROVIDER INFORMATION	Consumer Services Division		
Name	1200 West Third Street		
	Little Rock, AR 72201-1904 Phone: 501-371-2640 or 800-852-5494		
		Area of Practice Is this a managed care entity? Yes No	Fax: 501-371-2749
		Is this a managed care entity? Yes \( \subseteq \text{No} \subseteq \subseteq \)	E-mail: insurance.consumers@arkansas.gov
If so, are you an HMO, PPO, IPN, Self-funded Medicare HMO or Medicaid HMO?	Web site: www.insurance.arkansas.gov		
2 PATIENT/INSURER INFORMATION			
Patient's Name			
Patient's Address			
Name of Insured			
Insurance Company			
Policy No Gro	pup/Plan Number		
Release of Information: My signature on this form constitutes my auth ny information or documentation from any legal entity it deems necessar of this form will be considered valid authorization.	norization for the Arkansas Insurance Department to obtain by for the resolution of my complaint/inquiry. A photocopy		
SIGNATURE	DATE		