

# STATE OF NEW MEXICO OFFICE OF SUPERINTENDENT OF INSURANCE

**SUPERINTENDENT OF INSURANCE**  
John G. Franchini - (505) 827-4299

**DEPUTY SUPERINTENDENT**  
Alan Seeley - (505) 827-4307



P.O. Box 1689  
Santa Fe, NM 87504-1689  
1120 Paseo de Peralta, Room 428  
Santa Fe, NM 87501

**MANAGED HEALTH CARE BUREAU**  
1-855-427-5674 505-827-4601

## COMPLAINT FORM

The Managed Health Care Bureau will investigate this complaint to determine if there are any violations of the New Mexico Insurance Code, Managed Health Care Rule or insurance policy language.

Name \_\_\_\_\_ Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (other) \_\_\_\_\_

### Type of Complaint (Please circle)

Member Provider Other

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_ Name of Employer: \_\_\_\_\_

### Type of Health Care Plan?

- |   |   |
|---|---|
| <input type="checkbox"/> Individual               | <input type="checkbox"/> Group                    |
| <input type="checkbox"/> Medicaid                 | <input type="checkbox"/> Self-funded              |
| <input type="checkbox"/> Medicare Supplement Plan | <input type="checkbox"/> The NM School Authority  |
| <input type="checkbox"/> PPO                      | <input type="checkbox"/> The NM Retiree Authority |
| <input type="checkbox"/> Other: _____             | <input type="checkbox"/> Not sure                 |

### Name of Insurance Company

- Lovelace  Presbyterian  BCBS of New Mexico  Amerigroup New Mexico, Inc.  Molina  
 Other: \_\_\_\_\_

### DOES THIS COMPLAINT CONCERN?

- |   |   |
|---|---|
| <input type="checkbox"/> Payment of fees  | <input type="checkbox"/> Referral/Prior Authorization |
| <input type="checkbox"/> Treatment        | <input type="checkbox"/> Emergency Room               |
| <input type="checkbox"/> Physicians Issue | <input type="checkbox"/> Administrative Issue         |
| <input type="checkbox"/> Other _____      |   |

Have you started the appeal process? Yes  No  If yes, at what level is your complaint in the internal health plans process?

- Medical Director  
 Internal Panel Review  
 Exhausted Internal Review; Requesting an External Review Request

### PLEASE ATTACH A COPY OF YOUR BENEFITS BOOKLET

(Please turn page over)

PLEASE SUMMARIZE YOUR COMPLAINT. (ATTACH COPIES OF ANY DOCUMENTS THAT MIGHT BE RELATIVE TO YOUR COMPLAINT.)

