REQUEST FOR ASSISTANCE

TO:
OKLAHOMA INSURANCE DEPARTMENT
Five Corporate Plaza
3625 NW 56th, Suite 100
OKLAHOMA CITY, OK 73112

DATE: _____

Consumer Assistance
Phone: 1-800-522-0071
Local: 405-521-2991
Fax: 405-521-6652

❒Mr.
❒Mrs.
FROM: ❒Ms. _____ Telephone # (_____)_____-_____

Address: _____ City/State: _____ Zip: _____

If **Insured or Health Maintenance Organization ("HMO") member** is different than person requesting assistance, complete the following:

Insured or HMO Member's name: _____ Telephone #: (_____)_____-_____

Address: _____ City/State: _____ Zip: _____

Name of **INSURANCE CO**. about which you are requesting assistance:_____

Address: _____ **City/State**: _____ **Zip**: _____

Policy Number:_____ **Effective Date**: _____ **Type of Insurance**:_____
(Auto, Home, Commercial, Accident & Health)

Agent's Name:_____**Telephone No.: _(_____)**_____

Address:_____**City/State**_____**Zip**_____

Adjuster's Name:_____**Telephone No.: _(_____)**_____

Address:_____**City/State**_____**Zip**_____

Name of **HMO** about which you are requesting assistance:_____

Address: _____ **City/State**: _____ **Zip**: _____

Member ID Number or SSN:_____ **Date/s of Service**: _____

Provider's (Doctor) Name:_____**Telephone No.: _(_____)**_____

Address:_____**City/State**_____**Zip**_____

Provider's (Hospital) Name:_____**Telephone No.: _(_____)**_____

INQUIRY/COMPLAINT

Please give as detailed information as possible including dates, explanation, and what solution you feel is correct, Attach copies of any Other correspondence related to the complaint.

_____

_____

_____

_____
(Continue on the back)

With this knowledge, I give my consent to the release of all information in my medical records including any information concerning my identity and release the OKLAHOMA INSURANCE DEPARTMENT and its duly authorized agents and employees from any liability in connection with the release of the information contained herein.

Signature:_____Date:_____

FOR INSURANCE DEPARTMENT USE ONLY

Complaint number _____ Claim Analyst _____

Complainant type _____ Complainant letter _____

Entity number 1. _____ 2. _____ 3. _____

Entity type 1. _____ 2. _____ 3. _____

Entity function 1. _____ 2. _____ 3. _____

Entity letter 1. _____ 2. _____ 3. _____

Date Entered _____ Med. Supl. (A-J) _____

Coverage _____ 1. _____ 2. _____ 3. _____

Reason for complaint 1. _____ 2. _____ 3. _____

Dispositions 1. _____ 2. _____ 3. _____

Inquirer _____
(If not same as above)

Date resolved _____ Amount $ _____