Consumer Assistance Program
Department of Commerce
Capitol Hill, Saipan, CNMI
Consumer Complaint or Appeal Form-English
New: 10/7/2013 Rev:

Appeal or Complaint Form

Complete and sign this form if you wish to file a complaint or appeal regarding your health plan. A case will be opened for you at the CNMI Consumer Assistance Program (CAP) and a staff member will work with you to reach a resolution.

If you want to give another person the authority to assist you with your complaint, you must also complete the Authorized Assistant Form.

PATIENT INFORMATION

Required Information in Bold

How did you hear about the Consumer Assistance Program?____

First Name ______________________________Middle Initial _____**Last Name** ________________________________

Name of Parent or Guardian if Filing for Minor Child ____

Mailing Address ____

City ____**State** _________**Zip** _________________________________

Cell Phone # _______________________________ Home Phone # ____________________________________

What is the best way to contact you? (Circle one) Cell phone Home phone Email______________________

Health Plan Name/Name of Insurance Company____

Patient's Membership Number* _____________________Patient's Date of Birth (mm/dd/yy) _______________________

Medical Group Name* ____________________________Medical Group Number* ______________________________

**on your insurance card*

1. Are you on Medicaid? Yes No
2. Do you have Medicare or Medicare Advantage? Yes No
3. Have you filed a complaint or grievance with your health plan before? Yes No
4. Did your health plan cancel your insurance? Yes No
5. Please explain your complaint: (use a separate sheet if necessary)

   For example: What service did you want from your health plan, or provider?

   What was wrong with the service you got from your health plan, or provider?

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For Office Use Only

Case #_____________________________________ABC_______________.

Opened_______________Resolved_______________

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6 What is your health issue or diagnosis related to this complaint?

____

7 What treatment(s) have you received for this health issue?

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8 Please list the providers who have treated you for your health issue, if you have their names.

____

9 Have you filed another complaint about this problem with the CNMI Consumer Assistance Program or another government agency?

With the CNMI CAP office? Complaint File # (if known) ______________________________

With another government agency? Complaint File # (if known) ______________________________

Please list the government agency along with the names of individual staff members who have been assisting you:

____

10 Attach **copies** of documents related to your complaint, such as denials, your grievance to the health plan and its response, bills, explanations of benefits, and any medical records from non-contracted providers.

We cannot return originals.

I am asking the CNMI Consumer Assistance Program (CNMI CAP) to help make a decision about my problem with my health plan. I understand that a copy of my complaint and medical records may be sent to my health plan. I allow my providers, past and present, and my health plan to release my health records to the CNMI CAP. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the CNMI CAP to review these records and information. My permission will end one year from the date below, except as allowed by law. I understand that non-personally identifiable information from my case will be used in reports to the Department of Health and Human Services which can then use this data to strengthen oversight of the health insurance market (PHSA §2793, 42 U.S.C. §300gg-93). I can end my permission sooner if I wish by providing a written statement to the CNMI CAP Office. All the information that I have provided on this sheet is true.

If needed, is the authorized Assistant Form attached? ☐Yes No ☐

Patient or Parent Signature ____Date _______________

Mail or fax this form and any attachments to:

CNMI Consumer Assistance Program
C/O Department of Commerce
Box 10007
Saipan, MP 96950

Fax # (670) 664-3067

For Office Use Only

Case #_____________________________________ABC_______________.

Opened_______________Resolved_______________

NOTICE

The CNMI CAP uses your personal information to investigate your problem with your health plan and help you file an appeal if you qualify for one.

- You give us this information voluntarily. You do not have to give us this information.

- However, if you do not give us the information, we may not be able to investigate your complaint or assist you in filing an appeal.

- We may share your personal information, as needed, with the health plan and the organization that conducts the external review.

- We may also share your information with other government agencies as required or allowed by law.

- You have a right to see the personal information that the CAP has on file for you. To do this, contact the CAP office.