



Minnesota Department Of Health
Managed Care Section
P.O. Box 64882
St. Paul, Minnesota 55164-0882
(651) 201-5100 or 1-800-657-3916
Fax: 651 201-5186 E-mail: health.mcs@state.mn.us

HMO COMPLAINT - DATA PRACTICES NOTICE

1. The **Minnesota Government Data Practices Act** requires that we provide you with the following information:

- a) the purpose and intended use of the data you provide is to help the Minnesota Department of Health investigate and take action on your complaint.
- b) you are not legally required to provide any data to the department and you may refuse to provide any data. However, if you do not provide the requested data, the department may not be able to fully investigate and take action on your complaint.
- c) any data you provide may be used in action that the department brings against an HMO.
- d) the data you provide may be disclosed to certain persons or entities including individual staff members within the department whose job requires them to handle the complaint material, outside experts, the Office of the Attorney General, and other agencies that have legal authorization to obtain the data.

2. As part of your complaint, the department may find it helpful to send a copy of your complaint to your HMO. Unless you tell us not to, a copy of your complaint may be sent to your HMO.

Do not send a copy of my complaint to my HMO.

3. Please be advised that after our investigation is closed, an individual who is the subject of the complaint has the right to see the complaint file. If you are filing information on behalf of another person, the information you provide will become part of the complaint file and may be seen by the person that is the subject of the complaint once it is closed.

4. If it is determined that the complaint against your health plan does not fall under the jurisdiction of MDH we may forward it to the appropriate state agency for follow up (Commerce, Human Services or Minnesota Management and Budget). Please indicate if you authorize MDH to share your complaint with another state agency.

I authorize MDH to forward my complaint to the appropriate state agency

I DO NOT authorize MDH to forward my complaint to the appropriate state agency



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HMO Complaint

►Instructions

1. In order to assist you in addressing your complaint, you must complete this form including the Consent to Release.
2. Submit the completed form to the address above in the enclosed envelope or fax it to the number above.
3. Contact us at the number above if you have questions regarding the processing of your complaint.
4. Based on the information you supply, we will do our best to help you resolve your complaint.

Name of Person Submitting Complaint	Daytime Phone	Alternate Phone
Street Address		
City	State	Zip
Name of enrollee for whom you are filing this complaint (if you are not filing for yourself).	Relationship to enrollee	
Is there a family member you would like interviewed as part of this investigation? () yes () no If yes , please provide: name Relationship to you Phone Number		
Name of HMO (Check one.) <input type="checkbox"/> Blue Plus <input type="checkbox"/> Itasca Medical Care <input type="checkbox"/> PrimeWest <input type="checkbox"/> First Plan <input type="checkbox"/> Medica <input type="checkbox"/> Sanford Health Plan of Minnesota <input type="checkbox"/> Group Health/HealthPartners <input type="checkbox"/> Metropolitan Health Plan <input type="checkbox"/> South Country <input type="checkbox"/> Preferred One <input type="checkbox"/> UCare		
Type of Coverage <input type="checkbox"/> Group <input type="checkbox"/> Non group <input type="checkbox"/> PMAP <input type="checkbox"/> MinnesotaCare <input type="checkbox"/> Medicare <input type="checkbox"/> Other	Enrollee/Membership Number	Date of Birth
Name of Enrollee's Primary Clinic/Primary Care Physician		Date(s) of Incident

What would you like to see happen to resolve this complaint?



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Instructions for Consent to Release

It may be necessary to obtain copies of protected health information in order for MDH to fully investigate your complaint. We must have the **patient's** signed permission in order to obtain information. We have provided a Consent to Release form which will be used to obtain protected health information from your providers. The **patient** should sign and date the enclosed Consent to Release and return it in the envelope provided.

The list of providers may include clinics, physicians, hospitals, pharmacies and any other provider that may have protected health information relevant to your complaint. For each provider listed, please indicate the dates of service, or time period, that is relevant to your complaint.

For example:

Hospital X	July 1 – August, 2008
Dr. Y	September – September, 2008
Clinic Z	November – December, 2008

You may contact us at 651-201-5100 if you have any questions about filling out this form.



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Consent To Release

Patient's Name	Patient's Birth Date
Patient's HMO	HMO ID Number

By signing this form, I give permission to my HMO and to the care provider(s) listed below to provide a copy of my protected health information to the Minnesota Department of Health (MDH), or to allow them to be inspected and/or copies to be provided to the MDH. I give permission to my HMO and the provider(s) listed below to testify without limitations and without liability as to any and all findings and/or treatment referred to in them.

Provider(s) Use back for additional providers.	Date(s) of Service

This release takes effect on the date I sign and is good for 6 months or until the conclusion of the MDH investigation including any legal actions taken by MDH, whichever comes first. I may cancel this consent at any time by notifying the provider(s) listed above in writing. My cancellation will not have any effect on information released before the provider(s) received my written notice of cancellation.

Patient/Guardian Signature	Date
Relationship to Patient (if signed by guardian)	Reason Patient unable to sign