HOSPITAL BILL COMPLAINT FORM

HCAI-Legal-560 (New 8/24/2023)

- ✓ You can file your complaint online at: HospitalBillComplaintProgram.hcai.ca.gov.
- ✓ For free assistance with your complaint, you may contact the Health Consumer Alliance by visiting healthconsumer.org, or by calling (888) 804-3536.
- ✓ For HCAI to investigate whether you were wrongfully denied by the hospital for help paying your medical bills, you must have already applied for discount payment and/or charity care **before you file this complaint.**
- ✓ If you are mailing in your documents, please only include copies of documents. **Do not send originals, they will not be returned.**

SECTION 1: PATIENT INFORMATION

1. First Name, Middle Name, Last Name _____ 2. Preferred Name (optional) _____

3. Sex: ☐ Female ☐ Male ☐ Unknown ☐ Prefer not to say

4. Date of Birth: _____ 5. Is the patient deceased? ☐ Yes ▪ No

6. Is the patient a minor? ☐ Yes ☐ No

7. For minor patients, please print the name of their parent or legal guardian: _____

_____
8. Mailing Address, City, State, ZIP Code (5-digit), Country Name

_____ _____ _____
9. Primary Phone Number 10. Secondary Phone Number 11. Email address

12. Is someone, other than a parent or legal guardian of a child under the age of 18, helping you file your complaint? ☐ Yes ☐ No
If yes, please complete the Authorized Representative form.

SECTION 2: FAMILY INFORMATION

For patients 18 years of age and older, provide the full name, age, and relationship of the following: spouse, domestic partner, and dependent children under 21 years of age (whether living at home or not). For patients under 18 years of age, provide the full name, age, and relationship of the following: parents, caretaker relatives, and other children under 21 years of age of the parents or caretaker relatives. (If listing more than six family members, fill out addendum on page 10.)

Number	Full Name	Age	Relationship to Patient
1.			
2.			
3.			
4.			
5.			
6.			

SECTION 3: HOSPITAL INFORMATION

13. Name of hospital: _____

_____

14. Address, City, State, ZIP Code (5-digit)

15. Date of arrival: _____ 16. Date of discharge: _____

17. Did you receive a written estimate from the hospital? ☐ Yes ☐ No
If yes, attach supporting documentation, if available.

18. Dates of service(s) being billed by the hospital: _____
If more than one admission or multiple separate dates of service, please submit a separate complaint.

19. Have you paid any amount toward the service(s) in question? ☐ Yes ☐ No ☐ Unknown
If yes, provide supporting documentation and date of last payment, if available: _____

SECTION 4: HEALTH PLAN INFORMATION

20. Were the hospital services related to injuries caused by a third-party (such as a motor vehicle accident, crime, or work-related injury)?: ☐ Yes ☐ No ☐ Unknown

21. Were you enrolled in a health plan, insurance plan, and/or government insurance program (i.e., Medi-Cal, Medicare, Medicare Supplemental Insurance, etc.) for any of the dates of service in question? ☐ Yes ☐ No ☐ Unknown

If yes, for each type of coverage, please list name of plan, effective dates of coverage, membership ID number, and check box for type of coverage below, if available.

Primary Coverage	Dates of Coverage	Membership ID Number

☐ Commercial/Employer ☐ Medi-Cal ☐ Medicare ☐ Medicare Supplemental Insurance

Secondary Coverage	Dates of Coverage	Membership ID Number

☐ Commercial/Employer ☐ Medi-Cal ☐ Medicare ☐ Medicare Supplemental Insurance

Other Coverage	Dates of Coverage	Membership ID Number

☐ Commercial/Employer ☐ Medi-Cal ☐ Medicare ☐ Medicare Supplemental Insurance

Other Coverage	Dates of Coverage	Membership ID Number

☐ Commercial/Employer ☐ Medi-Cal ☐ Medicare ☐ Medicare Supplemental Insurance

22. Has a health plan, insurance plan, and/or government insurance program processed any of the claims for the services being billed by the hospital? ☐ Yes ☐ No ☐ Not Applicable ☐ Unknown

23. If yes, has the patient filed a complaint or appeal with their health plan, insurance plan, or government insurance program about the denial? ☐ Yes ☐ No ☐ Not Applicable ☐ Unknown

If yes, include a copy of the decision letter from the health plan, insurance plan, or government insurance program, and the date the complaint or appeal was resolved, if available.

24. Date complaint or appeal was resolved, if applicable and available:_____

SECTION 5: DEBT COLLECTION INFORMATION

25. Has the hospital sold this medical debt to collections or are you at risk of being sent to collections? ☐ Yes ☐ No ☐ Unknown

26. If yes, was the debt reported to a credit bureau or has it impacted your credit report/score?
☐ Yes ☐ No ☐ Unknown ☐ Not Applicable

If yes, please provide a copy of your credit report.

27. Name of debt collector, if applicable and available:_____

28. Date debt was sold to collections, if applicable and available:_____

29. Account number, if applicable and available:_____

All the information that I provided in filing this complaint is true and correct to the best of my knowledge.

_____
Patient's name (Print)

_____
Signature of patient or legal representative

Please Note: If the patient is unable to make medical and/or financial decisions, wants a representative to help with the complaint, or for patients who are deceased, please complete the attached Authorized Representative Form. Without a valid signature from the patient, the Authorized Representative must provide documentation of legal authority to act as the patient's authorized representative (i.e., Power of Attorney, Conservatorship documentation, Letter of Appointment of Executor, etc.).

SECTION 6: RELEASE OF INFORMATION

HCAI-Legal-562 (New 8/24/23)

I, [print patient name] _____ give my permission for the [print hospital name] _____ to share my complete health record including, but not limited to, financial information, billing, medical, mental health, substance use disorder, HIV, diagnostic imaging reports, and other records related to the complaint I filed, or filed on my behalf, with the California Department of Health Care Access and Information (HCAI), Hospital Bill Complaint Program (HBCP), for the purposes of determining whether the named hospital was compliant with the Hospital Fair Billing Act and associated regulations.

I understand that my substance use disorder records, if any, are protected under the federal regulations governing confidentiality and Substance Use Disorder Patient Records 42 C.F.R., Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts 160 &164, and cannot be disclosed without my written consent unless otherwise provided for by regulation.

This authorization to share my health information is valid until my complaint at HCAI is resolved. I understand that I am permitted to revoke this authorization to share health data at any time and I may do so in writing by mail to:

Department of Health Care Access and Information
Hospital Fair Billing Program
2020 West El Camino, Suite 1101
Sacramento, CA 95833

Unless otherwise revoked, this authorization will expire 12 months after the date of my signing this form or when my complaint is closed, whichever occurs earlier. The revocation will take effect when HBCP receives my request in writing, except to the extent HBCP or others have already relied upon my prior consent for release of medical information.

I understand this authorization to release health information is voluntary but that the HBCP cannot process my complaint about hospital billing without signing this release.

Unless required by law, California law prohibits HCAI from further disclosing my health information unless the HCAI obtains another authorization. I understand that if I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I understand I have a right to receive a copy of this authorization.

Patient Signature:_____ Date:_____

Print your name: _____

If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Date: _____

Describe below how this person has legal authority to sign this form:

_____

DEMOGRAPHIC INFORMATION

The following demographic questions will only be used for reporting and analysis purposes. **This information is optional. If you do not wish to provide this information, it will not affect the outcome of your complaint in any way.**

1. LANGUAGE

Preferred language spoken: _____

Would you like us to communicate with you in your preferred language? ☐ Yes ☐ No

2. RACE AND/OR ETHNICITY

What is your race and/or ethnicity?
Select all categories and subcategories that apply and enter any additional details in the spaces below. Note, you may report more than one group.

AMERICAN INDIAN or ALASKA NATIVE ☐
Provide details below.
☐ Navajo Nation ☐ Write-in option:_____

ASIAN OR ASIAN AMERICAN ☐
Provide details below.
☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino/a ☐ Hmong ☐ Japanese ☐ Korean
☐ Laotian ☐ Pakistani ☐ Vietnamese ☐ Write-in option:_____

BLACK OR AFRICAN AMERICAN ☐
Provide details below.
☐ African American ☐ Barbadian ☐ Ethiopian ☐ Ghanaian ☐ Haitian ☐ Jamaican ☐ Kenyan
☐ Nigerian ☐ Somali ☐ South African ☐ Sudanese ☐ Write-in option:_____

HISPANIC or LATINA/O ☐
Provide details below.
☐ Colombian ☐ Cuban ☐ Dominican ☐ Ecuadorian ☐ Guatemalan ☐ Honduran
☐ Mexican or Mexican American ☐ Puerto Rican ☐ Salvadoran ☐ Spaniard
☐ Write-in option:_____

MIDDLE EASTERN or NORTHERN AFRICAN ☐
Provide details below.
☐ Afghan ☐ Algerian ☐ Armenian ☐ Egyptian ☐ Iranian ☐ Iraqi ☐ Israeli ☐ Kurdish
☐ Lebanese ☐ Moroccan ☐ Syrian ☐ Write-in option:_____

NATIVE HAWAIIAN or PACIFIC ISLANDER ☐
Provide details below.
☐ Chamorro ☐ Chuukese ☐ Fijian ☐ Guamanian ☐Marshallese ☐ Native Hawaiian ☐ Palauan
☐ Samoan ☐ Tahitian ☐ Tongan ☐ Write-in option:_____

WHITE ☐

Provide details below.

☐ Dutch ☐ English ☐ French ☐ German ☐ Irish ☐ Italian ☐ Norwegian ☐ Polish

☐ Portuguese ☐ Russian ☐ Scottish ☐ Write-in option:_____

3. GENDER IDENTITY

Provide details below.

☐ Female ☐ Male ☐ Female-to-Male/Transgender Male/Trans Man

☐ Male-to-Female/Transgender Female/Trans Woman

☐ Genderqueer (neither exclusively male nor female) ☐ Don't know/Prefer not to say

☐ Write-in option: _____

INFORMATION PRACTICES ACT OF 1977 NOTICE

The Information Practices Act of 1977 (California Civil Code section 1798.17) requires the following notice:

- Health and Safety Code section 127436 gives the Department of Health Care Access and Information (HCAI) the authority to investigate hospital billing complaints related to a hospital's discount payment and/or charity care policies.
- HCAI's Hospital Fair Billing Program uses your personal information to investigate your hospital billing complaint.
- You may provide this information to HCAI voluntarily, though it is not required. However, if you do not provide requested information, HCAI may not be able to investigate your complaint.
- HCAI may share your personal information, as needed, with the hospital and providers to investigate your complaint.
- HCAI may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. Should you need further information or have questions about the privacy of personally identifiable data maintained by the HCAI, please contact the Privacy Officer at:

  Department of Health Care Access and Information
  Privacy Officer
  2020 West El Camino, Suite 800
  Sacramento, CA 95833
  Privacy.Officer@HCAI.ca.gov
  hcai.ca.gov/home/privacy-policy/

BEFORE YOU FILE

If you would like HCAI to investigate whether you were wrongfully denied by the hospital for help paying your medical bills, you must have already applied for financial assistance at the hospital where you received services. If you have not yet applied with the hospital, you should contact the hospital for more information on how to apply. If you would like assistance, you may call the Health Consumer Alliance at 888-804-3536, or go to healthconsumer.org for more information.

HOW TO FILE

1. File online at HospitalBillComplaintProgram.hcai.ca.gov (this is the fastest method to file). Follow the instructions online and sign the Complaint Form.
2. If you are using an Authorized Representative, complete the 'Authorized Representative Form.'
3. Attach a copy of your recent W-2 or six months of paystubs.
4. You may include other documents that support your request such as any of the following:
   - Written estimate from the hospital.
   - Any documentation showing payments made toward the billed services.
   - Any communications with your health plan or government insurance program about the billed services.
   - Proof medical debt was sold to collections or is at risk of being sent to collections.
   - A copy of your credit report if your credit score was affected.

Please note, only documentation that is related to the date(s) of service listed in your complaint will be considered.

5. If you are not submitting online, please mail your Complaint Form and any supporting documentation to:

   Department of Health Care Access and Information
   Hospital Bill Complaint Program
   2020 West El Camino, Suite 1101
   Sacramento, CA 95833

ADDITIONAL FAMILY MEMBER ADDENDUM

HCAI-Legal-564 (New 8/24/23)

Please complete this page if you have additional family members to add. If more space is needed, please make additional copies of this page to submit with your complaint.

FAMILY INFORMATION

For patients 18 years of age and older, provide the full name, age, and relationship of the following: spouse, domestic partner, dependent children under 21 years of age (whether living at home or not).

For patients under 18 years of age, provide the full name, age, and relationship of the following: parents, caretaker relatives, and other children under 21 years of age of the parents or caretaker relatives.

Number	Full Name	Age	Relationship to Patient
1.			
2.			
3.			
4.			
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11.			
12.			
13.			
14.			

AUTHORIZED REPRESENTATIVE FORM

HCAI-Legal-561 (New 8.24.23)

- If you want to give another person permission to represent you or assist you with your complaint, complete Parts A and B below.
- **If you are a parent or legal guardian submitting this complaint for a child under the age of 18, you do not need to complete this form.**
- If you are filing this complaint for a patient and you are designated by law to act on behalf of the patient, please complete Part B only. You must attach a copy of the documentation that gives you legal authority to act as the patient's authorized representative.

PART A: COMPLETED BY PATIENT

I allow the person named below in Part B to act on my behalf in my complaint filed with the Department of Health Care Access and Information (HCAI). I allow HCAI staff to share financial information and information about my medical condition(s) and related care with the person named below. I understand and acknowledge that these records may include financial information, billing, medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to the complaint.

My approval of this representation is voluntary, and I have the right to end it. If I want to end it, I must do so in writing.

1. Patient Signature _____ 2. Print Patient Name _____

3. Date: _____

PART B: COMPLETED BY PERSON ASSISTING PATIENT

4. Name of Patient: _____

5. Name of Authorized Representative: _____

6. Relationship to Patient: _____

_____

7. Mailing Address, City, State, ZIP Code (5-digit), Country Name

8. Phone Number _____ 9. Email Address _____

10. Signature of Authorized Representative _____ 11. Date _____

12. ☐ My documentation of legal authority to act as the patient's authorized representative is attached. (Check if applicable).