LOUISIANA DEPARTMENT OF INSURANCE
Office of Health Insurance
P. O. Box 94214 – 1702 North 3rd Street, 70802
Baton Rouge, LA 70804
(800) 259-5300 (225) 219-4770 Fax (225) 342-5711

PROVIDER PROMPT PAYMENT MULTIPLE CLAIM COMPLAINT FORM

Part I

SECTION 1

Provider Information		
Name of Provider		
Address		
City	State	Zip Code
Contact Person		
Telephone Number	E-mail Address	

SECTION 2

Complete Appropriate Block as it Applies	√ Appropriate Box as it applies to claim submission
☐ Contracted Provider Number:	☐ Electronic Claim – Clearinghouse Name and Telephone Number if applicable:
☐ Non-Contracted Provider	☐ Non-Electronic Claim

SECTION 3

Complaint Against		
Company Name	Telephone Number ( )	
Address		
City	State	Zip Code

DEPARTMENT USE ONLY – THIS COMPLAINT IS BEING RETURNED FOR THE FOLLOWING REASON (S)	
☐ Insufficient / Incomplete Information	
☐ Self-Funded Private Employer or Governmental Plan – No Jurisdiction	
☐ Not Against an Authorized Insurance Company	
☐ Contract Dispute – Please Follow Appropriate Grievance Procedures	
☐ Other:	
Returned by:	Date Returned:

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PROVIDER PROMPT PAYMENT COMPLAINT FORM

Part II

CHECK ONE BOX ONLY

- ☐ **Claims were not paid timely**
- ☐ **Claims rejected as not received. When resubmitted, denied for non-timely filing**
- ☐ **Claims rejected (for any other reason). When resubmitted denied for non-timely filing**
- ☐ **Unreasonable requests for medical information**
- ☐ **Unreasonable COB inquiry-No other insurance**
- ☐ **Denial for lack of authorization**
- ☐ **Audit of claim after allowed period**
- ☐ **Recoupment of payment without notice**
- ☐ **Other – NON-Contractual (Explain below)**