STATE OF ALASKA
ALASKA DIVISION OF INSURANCE
550 W. 7th Avenue, Suite 1560 Anchorage, Alaska 99501-3567
Tel.: (907) 269-7900 Fax: (907)269-7910 TTY/TDD: 711 or (800) 770-8973

PROVIDER COMPLAINT / INQUIRY FORM

Part I - Provider Information

Provider/Facility/Clinic/Pharmacy:_____
Contact Name:_____
Mailing Address:_____ City:_____
State:_____ Zip code:_____ Best Phone:_____
Email:_____

Part II – Patient Information

Patient's Name: _____
Patient's Age: ☐ Under 18 ☐ 18 to 25 ☐ 26 to 49 ☐ 50 to 64 ☐ 65+

Part III - Policy Holder Information

Policy Holder's Name:_____
Mailing Address: _____ City:_____
State:_____ Zip Code:_____ Best Phone:_____
Email:_____
Employer:_____

Part IV - Insurance Information

Insurance/Claim Administrator:_____
Mailing Address: _____ City:_____
State:_____ Zip Code:_____ Best Phone:_____
Email:_____
Policy Type (Health/WC/Auto):_____ Effective Date:_____
Policy/Group Number:_____ Member ID Number:_____
Is the patient/insured's plan self-funded? ☐ Yes ☐ No ☐ Unknown
Is this complaint being filed against a Pharmacy Benefits Manager (PBM)? ☐ Yes ☐ No

- If yes, please fill out Part VI.

Part V - Claim Information

Claim Number:_____ Date of Service:_____ Date Claim Submitted: _____

- Did the insurance company say the healthcare service is not covered under the health plan? ☐ Yes ☐ No
- Were the services provided at an in-network facility in-network? ☐ Yes ☐ No
- Were the services emergency services? ☐ Yes ☐ No

Part VI – Pharmacy Benefits Manager(PBM)

PBM Name:_____

Mailing Address:_____ City:_____

State:_____Zip Code:_____ Phone:_____

Email:_____

Other Identifier:_____

Section VII - Factual Statement of the Problem (Required)

Please provide a factual statement of the encountered issue. Enclose a copy of the patient's claim, all written correspondence, and a copy of all appeals.

Signature:_____ Date:_____

Printed Name:_____ Title/Position:_____

This form is to only be used by healthcare providers and facilities to file a complaint against an insurance company. This is not the appropriate form for a complaint against a healthcare provider or facility

Please submit this form and your required documentation by mail, fax or email:

Alaska Division of Insurance Attn: Consumer Services
550 West 7th Avenue, Suite 1560
Anchorage, AK 99501
Fax: (907) 269-7910
consumerservices@alaska.gov