Department of Health and Human Services  
Health Insurance Portability and Accountability Act of 1996 (HIPAA)  
Electronic Health Care Transactions and Code Sets Complaint Submission Form

You may use this form to file a HIPAA complaint. This form is for the submission of complaints about covered entities that are not compliant with the HIPAA electronic health care transactions and code set standards. This form should not be used to file complaints regarding the privacy of health information.

If you choose, you can now file on-line at [http://cms.hhs.gov/hipaa/hipaa2/default.asp](http://cms.hhs.gov/hipaa/hipaa2/default.asp). Or you may mail your complaint to the following address:

HIPAA Complaint  
7500 Security Blvd., C5-24-04  
Baltimore, MD 21244

Section A: Your Contact Information (person or entity filing the complaint)

First Name: ____________________  Middle Initial: ____  Last Name: ____________________
Title: __________________________  Organization: __________________________
Street Address Line 1: __________________________________________________________
Street Address Line 2: __________________________________________________________
City: _____________________________  State: ____________________  Zip Code: ____________
Telephone Number: __________________________  Extension: ______________
Email Address: __________________________

Section B: Information about the Entity that you are filing a complaint about

Name of Covered Entity: __________________________________________________________
Tax Identification Number: ____________________  Medicare Identification Number: __________
Type of Covered Entity (Check one)

___ Health Care Clearinghouse  
___ Health Plan  
___ Health Care Provider (choose one)  
  O Dentist  
  O DME Supplier  
  O Home Health Agency  
  O Hospice  
  O Hospital  
  O Nursing Home  
  O Pharmacy  
  O Physician/Group Practice  
  O Other

Covered Entity Contact Person:
First Name: ____________________  Middle Initial: ____  Last Name: ____________________
Title: __________________________
Street Address Line 1: __________________________________________________________
Street Address Line 2: __________________________________________________________
City: _____________________________  State: ____________________  Zip Code: ____________
Telephone Number: __________________________  Extension: ______________
### Section C: Specific Complaint

#### Type of Complaint:
- [ ] Transactions (check all that apply)
  - O Health claims and equivalent encounter information
  - O Enrollment and disenrollment in a health plan
  - O Eligibility for a health plan
  - O Health care payment and remittance advice
  - O Health plan premium payments
  - O Health claim status
  - O Referral certification and authorization
  - O Coordination of benefits

- [ ] Code Sets (check all that apply)
  - O ICD-9 diagnosis
  - O ICD-9 procedure
  - O HCPCS
  - O CPT-4
  - O Dental
  - O NDC

Provide comments in the area below:

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