

# REQUEST FOR ASSISTANCE

**TO:**

OKLAHOMA INSURANCE DEPARTMENT  
 Five Corporate Plaza  
 3625 NW 56th, Suite 100  
 OKLAHOMA CITY, OK 73112



DATE: \_\_\_\_\_  
 Consumer Assistance  
 Phone: 1-800-522-0071  
 Local: 405-521-2991  
 Fax: 405-521-6652

FROM:  Mr.  
 Mrs.  
 Ms. \_\_\_\_\_

Telephone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

If **Insured or Health Maintenance Organization ("HMO") member** is different than person requesting assistance, complete the following:

**Insured or HMO Member's name:** \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of **INSURANCE CO.** about which you are requesting assistance: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_ **Type of Insurance:** \_\_\_\_\_  
(Auto, Home, Commercial, Accident & Health)

**Agent's Name:** \_\_\_\_\_ **Telephone No.:** (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

**Adjuster's Name:** \_\_\_\_\_ **Telephone No.:** (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Name of **HMO** about which you are requesting assistance: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Member ID Number or SSN:** \_\_\_\_\_ **Date/s of Service:** \_\_\_\_\_

**Provider's (Doctor) Name:** \_\_\_\_\_ **Telephone No.:** (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

**Provider's (Hospital) Name:** \_\_\_\_\_ **Telephone No.:** (\_\_\_\_) \_\_\_\_\_

## INQUIRY/COMPLAINT

Please give as detailed information as possible including dates, explanation, and what solution you feel is correct, Attach copies of any Other correspondence related to the complaint.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Continue on the back)

With this knowledge, I give my consent to the release of all information in my medical records including any information concerning my identity and release the OKLAHOMA INSURANCE DEPARTMENT and its duly authorized agents and employees from any liability in connection with the release of the information contained herein.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

FOR INSURANCE DEPARTMENT USE ONLY			
Complaint number _____	Claim Analyst _____	Date Entered _____	Med. Supl. (A-J) _____
Complainant type _____	Complainant letter _____	Coverage _____	1. _____ 2. _____ 3. _____
Entity number 1. _____ 2. _____ 3. _____		Reason for complaint 1. _____ 2. _____ 3. _____	
Entity type 1. _____ 2. _____ 3. _____		Dispositions 1. _____ 2. _____ 3. _____	
Entity function 1. _____ 2. _____ 3. _____		Inquirer _____	
Entity letter 1. _____ 2. _____ 3. _____		<small>(If not same as above)</small>	
		Date resolved _____	Amount \$ _____

