



Credentialing and Contract Complaint

To register a complaint, please complete this form and submit to the Ohio Department of Insurance. Your complaint will be forwarded directly to the third-party payer. They should respond to you within 15 working days of receipt from our Department. Please do not send backup documentation with this form.

Ohio Department of Insurance

Provider Complaint Unit
50 W. Town Street, Suite 300
Columbus, Ohio 43215-1067

(800) 686-1526 or Fax (614) 644-3744

FOR DEPARTMENT USE ONLY

Ohio Department of Insurance
Case # _____

Provider name _____ Contact person _____
Address _____
City _____ State _____ Zip _____
Daytime phone # _____ Fax # _____
Email _____

Name of third-party payer _____
Third-party payer contact person, phone, and address _____

Type of Provider: Select Type of Provider: (Check One)

- Physician
- Podiatrist
- Dentist
- Pharmacist
- Chiropractor
- Optometrist
- Psychologist
- Advanced Practice Nurse
- Occupational Therapist
- Massage Therapist
- Physical Therapist
- Other _____

Type of Complaint: * Please specify provider type if it is not accurately listed above

1. Credentialing

Date Provider Sent the Credentialing Form to TPP _____

Please Note: The Insurance Company has 90 days to process your application.
Please do not file if this time frame has not been exhausted.

2. Contractual

Select Contractual Type Rates/Fee Schedule-Payments not in accordance with contract
 Provider Information sold, rented, or given to another entity
 Material change to contract not disclosed properly

Attach an additional summary letter if you feel it is necessary to substantiate your complaint

Other Comments: _____

