Rev. 10/19

KENTUCKY DEPARTMENT OF INSURANCE
HEALTH CARE PROVIDER "CLEAN CLAIM" COMPLAINT FORM

Must include a patient Health Insurance Card

Office Name/Provider Name: _____

Provider Type (e.g., pharmacist, physician, etc.): _____ *KY License #:* _____

Address: _____ *City:* _____ *State:* _____ *Zip:*_____

Phone: ( ) _____ *Contact Person Name:* _____ *Fax: ( )* _____
(First & Last Name)

Insurance Company Name: _____

Contact Name: _____ *Fax: ( )* _____

Policy Holder: _____ *Policy #:* _____

Patient Name: _____ *Group #:* _____

DESCRIPTION OF CLAIM AND VERIFICATION OF UNTIMELY PAYMENT

Date(s) services rendered: _____ *Amount of original claim: $*_____

Date claim first sent to Insurer: _____ *Sent by:* ☐ *Mail* ☐ *Electronic* ***(Attach copy of original claim (UB-92, HCFA-1500. etc.) with any attachments sent)***

Are you a participating provider with the Insurer? ☐ *Yes* ☐ *No*

Has the Insurer acknowledged receipt of the claim? ☐ *Yes* ☐ *No If yes, when* _____ ***(Attach copy)***

Has the Insurer denied receipt of the claim? ☐ *Yes* ☐ *No* ***(If yes, attach any documented written proof of your transmittal)***

Has the Insurer denied the claim in writing? ☐ *Yes* ☐ *No* ***(If yes, attach copy)***

Has the Insurer made any payment? ☐ *Yes* ☐ *No If yes, how much $* _____, *and when* _____

Has the Insurer requested additional information? O Yes O No If yes, what additional information was provided by you to the Insured and when was it provided _____

_____ ***(Attach copy)***

Please mail this completed form and all supporting documentation to: ***Consumer Protection and Education Division*** ***Kentucky Department of Insurance*** ***P.O. Box 517*** ***Frankfort, KY 40602-0517***	***On behalf of the provider, I certify that the above information is correct:*** ***Signature:*** _____ ***Title:*** _____ ***Date:***

Please remember, without proper documentation, your complaint cannot be processed!
The use of this form is suggested but not mandatory
Questions: Call 502-564-6034 or 800-595-6053
One form per patient. Form may include multiple dates of service for that patient. Additional documentation may not include other party's information.