STATE OF CALIFORNIA Dave Jones, Insurance Commissioner

DEPARTMENT OF INSURANCE
CONSUMER SERVICES AND MARKET CONDUCT BRANCH
CONSUMER SERVICES DIVISION
300 SOUTH SPRING STREET, SOUTH TOWER
LOS ANGELES, CA 90013
www.insurance.ca.gov
CSD-002-P
Revised: 02/11/2015

HEALTH REQUEST FOR ASSISTANCE (HRFA)

Name_____ Daytime Phone: ( ) _____

Address _____ Alternate Phone: ( ) _____

City /Zip _____ Email address: _____

Insured's Date of Birth _____ Insured's Gender ☐ Male ☐ Female

==========

Name of the policyholder if different from your name: _____

Type of Insurance: Health ☐ Dental/Vision ☐ Medicare Supplement ☐ Other ☐ _____

What is the primary language spoken in your home? _____

In order to ensure all Californians have access to health insurance, please identify your race/ethnicity:

_____

Complete name of insurance company involved: _____

Policy number: _____ Claim number: _____

Date(s) of Medical Services Provided (if applicable) _____

Insurance Agent (if applicable) _____Agent License Number_____

Agent Phone Number: _____ *Agent Email Address:* _____

Agent Street Address _____ *City/State*_____/_____ *Zip* _____

Have you contacted the company or the agent? Yes ☐ No ☐

*If yes, state the date(s) and person(s) contacted*_____

Have you reported this to any other governmental agency? Yes ☐ No ☐

Name of Agency: _____

*Date Reported:*_____ *Case Number* _____

Have you previously written to the Department of Insurance about this matter? Yes ☐ No ☐
File number (if available) _____ *Date* _____

Are you represented by an attorney in this matter? Yes ☐ No ☐

Has a lawsuit been filed? Yes ☐ No ☐

Is the case currently in active litigation? Yes ☐ No ☐ *If yes, we will defer the regulatory investigation until the finality of the litigation. We ask that you still complete this form so we have a record of your issue. Once the matter is concluded, we would welcome any information regarding violations of insurance law by the insurer that you or your attorney are willing to provide.*

Briefly, describe your problem (use additional paper if needed):

What do you consider to be a fair resolution to your problem?

In order for us to effectively begin our investigation, please provide any supporting documentation you may have related to this matter along with your *Health Request for Assistance (HRFA).*

☐ Copy of insured's insurance identification card – both sides
☐ Copies of correspondence between you and the insurance company/agent, including all related Explanation of Benefits (EOBs)
☐ If you wish to give authority to someone to assist you in filing this *Health Request for Assistance (HRFA)*, please complete the *Authorization and Designation of Agent* form.

PLEASE READ:
I understand that a copy of this form and all documentation submitted will be provided to the licensee involved in this Request for Assistance.

_____ _____
(Signature) (Date)

State Of California
Department of Insurance
Authorization and Designation of Agent

- If you want to give someone the authority to assist you in the filing of your complaint please fill in Parts A and B below.
- If you are a parent or legal guardian filing this complaint for a child under the age of 18, you do not need to complete this form.
- If you are filing a complaint for a consumer who cannot complete this form and you have legal authority to act for this consumer, please complete Part B only. Also send a copy of the power of attorney for health care decisions or other legal document that says you can make decisions for the consumer.

PART A: COMPLAINANT

I allow the person named below in Part B to assist me in completing a complaint filed with the California Department of Insurance (CDI). I allow the CDI to share my personal information with the person named below in Part B. This may include information about my medical condition(s) and care if applicable and may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want it to end, I must do so in writing.

Name of Complainant (Print) _____

Complainant Signature_____ Date_____

PART B: PERSON ASSISTING THE COMPLAINANT

If Applicable, Name of Organization (Please print)
_____

Name of Person Assisting (Please print)
_____

Signature of Person Assisting _____

Address _____

Relationship to Complainant
_____

Daytime Phone # _____ Evening Phone # _____

☐ My Power of Attorney for health care decisions or other legal document is attached.

Return the completed form to California Department of Insurance, Consumer Services Division, 300 S. Spring Street, Los Angeles, CA 90013. If you have any questions, the Department can be reached at (800) 927-4357, Outside of California (213) 897-8921.

Effective January 21, 2013