



**LISA MADIGAN
ILLINOIS ATTORNEY GENERAL**

**Health Care Bureau
100 West Randolph Street
Chicago, Illinois 60601**

**Hotline Number: 1-877-305-5145; Fax Number: 1-312-793-0802
TTY: 1-312-964-3013; Website: www.IllinoisAttorneyGeneral.gov**

Your Information

Your Name: Mr. Mrs. Ms.

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Daytime Phone No.: _____ Evening Phone No.: _____

E:mail Address (Optional): _____

Patient's Information

Patient's Name: _____
Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone No.: _____ Date of Birth: _____

Senior Citizen? Yes No

Your Complaint Is Against (Respondent)

Name: _____ Contact Person: _____ Phone: _____
Street Address: _____ City/Town: _____ State: _____ Zip: _____ County: _____
Account No.: _____ Date of Service: _____ Is the claim in collections? Yes No
If yes, please provide name, phone, account, and contact person: _____

Total Cost: _____ Amount Paid: _____ Money Owed: _____ By Whom (i.e., Ins. Co.) _____
How Paid:(i.e., cash, check, credit card, etc.): _____ Have you complained to the company/individual? Yes No
Complained by: Mail Phone In Person Facsimile Other _____
Person Contacted: _____ Job Title: _____ Phone No.: _____
Nature of response: _____ Date of response: _____
Did you sign a contract? Yes No. If yes, please attach a copy.
Was the product/service advertised? Yes No. Please attach a copy of the advertisement, if available.
Who referred you to this office? _____ Is court action pending? Yes No
Has this matter been submitted to another agency/attorney? Yes No. If yes, please provide the name and phone number.

Primary Insurance Information At The Time of Service

Insurance Name: _____ Contact Name: _____ Phone No.: _____

Address: _____ City/Town: _____ State: _____ Zip: _____ County: _____

Type of Plan: HMO PPO Dental Medicare Supplemental Other _____

Employer Name: _____ Phone No.: _____ Self Insured? Yes No

Employer Address: _____ City/Town: _____ State: _____ Zip: _____ County: _____

Policy Holder: _____ Group: _____ ID#: _____

Secondary Or Supplemental Insurance At The Time of Service

Insurance Name: _____ Contact Name: _____ Phone No.: _____

Address: _____ City/Town: _____ State: _____ Zip: _____ County: _____

Type of Plan: HMO PPO Dental Medicare Supplemental Other _____

Policy Holder: _____ Group: _____ ID#: _____

A Description of Your Problem. (Please use additional paper, if necessary. Also, attach copies of all documents related to your complaint). PLEASE DO NOT SEND ORIGINALS.

Type of Resolution/Relief You Are Seeking. (i.e., exchange, repair, money back, product delivery, etc.).

In filing this complaint, I understand that the Attorney General is not a private attorney, but rather enforces laws designed to protect the public from misleading or unlawful business practices. I also understand that if I have any questions concerning my legal rights or responsibilities, I should contact a private attorney. I have no objection to the contents of this complaint being forwarded to the business or the person the complaint is directed against, unless box checked below. The above complaint is true and accurate to the best of my knowledge.

Signature

Date

Check here if you only want to notify our office of your concerns and do not want a mediation process initiated.

We recommend that you print an additional copy(s) of this filled out form for your records