KWAME RAOUL
ILLINOIS ATTORNEY GENERAL
Health Care Bureau
100 West Randolph Street
Chicago, IL 60601
Hotline Number: 1-877-305-5145 *** Fax Number: 1-312-793-0802 *** TTY: 1-312-964-3013
Website: www.IllinoisAttorneyGeneral.gov Email: HealthCare@ilag.gov

Your Information

Select one: **Your Name:**

Mailing Address:

City: **State:** **Zip:** **County:**

Daytime Phone No. **Evening Phone No.**

Email Address (Optional)

Contact Person:

Patient's Information

Select one: **Patient's Name:**

Address:

City: **State:** **Zip:** **County:**

Phone No.: **Date of Birth:**

Senior Citizen?

Your Complaint Against (Respondent)

Name: **Contact Person:** **Phone No.:**

Address: **City:** **State:** **Zip:** **County:**

Account No.: **Date of Service:** **Is claim in collections?**

If claim is in collections, please provide name, phone, account, and contact person:

Total Cost: **Amount Paid:** **Amount Owed:** **By Whom (i.e., Ins. Co.):**

How Paid (i.e., Cash, Check, Credit Card, Insurance, etc.) **Have you complained to the company/individual?**

Complained by: **If Other, please specify:**

Person Contacted: **Job Title:** **Phone No.:**

Nature of response: **Date of response:**

Did you sign a contract? **Was the product/service advertised?**

Who referred you to this office? **Is court action pending?**

Has this matter been submitted to another agency / attorney? **If yes, please provide the name, address, & phone number in the space provided below:**

InsuranceName: **Contact Name:** **Phone No.:**

Address: **City:** **State:** **Zip:** **County:**

Type of Plan: **If Other,please specify:**

Employer Name: **Phone No.:** **Self Insured?**

Employer Address: **City:** **State:** **Zip:** **County:**

Policy Holder: **Group:** **ID #:**

Secondary or Supplemental Insurance at the Time of Service

Insurance Name: **Contact Name:** **Phone No.:**

Address: **City:** **State:** **Zip:** **County:**

Type of Plan: **If Other, please specify:**

Policy Holder: **Group:** **ID #:**

A Description of your Problem

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

If you are concerned about transmitting patient health information over this unencrypted website, you should print and fill out the Health Care Bureau complaint form off line and mail the documents to this office.

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 the box is checked below. The above complaint is true and accurate to the best of my knowledge.

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

Please print and send the completed form to the address at the top of this complaint form.

Print Form Reset Form