Department of Insurance

Credentialing & Contract Complaint

Market Conduct Division, 50 W Town Street, 3rd Floor - Suite 300, Columbus OH 43215
614-644-2577 | 614-387-3327 (Fax) | insurance.ohio.gov

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

email: **MKD.Provider.Complaints@insurance.ohio.gov**
or Fax 1-614-644-3744

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
- ☐ Dentist
- ☐ Chiropractor
- ☐ Psychologist
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Podiatrist
- ☐ Pharmacist
- ☐ Optometrist
- ☐ Advanced Practice Nurse
- ☐ Massage 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

Other Comments: ____
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