Create Account and Sign In Instructions

On the left hand side of the page under the “Sign In” box choose “Create Account”
Complete the boxes shown.

Your temporary password will be sent to the email address you provided on the form.
Once you receive your password, return back to the “Sign In” page. Enter your password in the box and click on sign in.
Click on “Available Applications” to request access to the Provider Complaint Forms.

Then click “Request Access”.
To customize your account, click on “Manage” in the upper left corner and choose “Control Panel”.
Next click on “My Account”
Customize your account by completing the appropriate fields. Click the “save” button on the right before moving to the next section such as addressee.
Provide your address information. Put the name of your business in the “Street 1” box. If you want to include more than one address click on the green “+”. Once you have completed the fields, click on “save” and then update your phone numbers by choosing “Phone Numbers”.
Update your telephone number(s). Use the green "+" sign to add your fax or an alternate phone number.
You may now file a complaint. Click on “Provider Complaint Forms” in the “Application Access” box.
In the middle of the page is a drop down box that will let you choose the type of complaint you are filing.

No-fault is for automobile accident claims. Prompt pay is for health insurance or HMO coverage. W/C (workers’ compensation) is for work related injuries.
The information you added to your profile will populate on the form. Your name will appear in the “Provider Name” field, you will need to move your name to the “Contact Information” section if you are not the provider of the services.
Please input the provider group name, if applicable. This is also the same field to enter the name of a facility where the services were provided. If submitting under a group name, be sure to include the name of the provider who actually performed the services. You must include the Tax ID number that was on the claim form.
Scroll down on the form and add the patient information and the name of the insurer or HMO.
The last section is the date of service information. Enter the date of service, the date the claim was submitted and whether it was sent electronically or not. Enter the CPT code and amount billed. Be sure to include a brief explanation of the problem in the comments box.

If billing for inpatient services, use the admit date as the date of service, enter zeroes for the CPT code, indicate the discharge date and the billing code information (DRG, Rev Code, etc.) in the comments box as well as a brief explanation of the problem.
Click the “Review” button and the system will alert you if any mandatory fields are missing information. Once errors are corrected click “Review” again.
You may now attach supporting documents by using the “Browse” and “Upload” buttons at the bottom of the page.
Once you click “Upload”, the document that you attached will appear at the bottom of the form. Click the “Submit” button to complete the process.
You will be asked to confirm that you want to submit the complaint.
This notice will appear at the top of the page once the complaint has been submitted. Please note that the AOB (authorization to pay benefits) is only required for no-fault complaints. You can also print the complaint for your records if desired. Acknowledgement of the complaint and the Department’s file number will be sent to your email address.
An example of the email acknowledgement is shown below.

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Online Complaint Received
by stnyrics to laura.dillon
04/17/2012 12:10 PM
Show Details

This is an automated message. Please do not reply to this address as your email may not be received.

Your complaint has been successfully submitted to our Consumer Assistance Unit!

Your Complaint number is: CSB-2012-814479

Please use the following link if you would like to add additional information to your complaint at any time in the future:
https://wsporal.dliny.gov/webguest/applications/consumer-complaint

If your complaint involves a health insurance claim made under Medicare or a Medicare HMO, you have 60 days from receipt of the Medicare Explanation of Benefits or 60 days from receipt of the Medicare HMO Notice of Initial Determination to file a written appeal. Please refer to these documents or contact the Social Security Administration.

If your complaint involves the denial of a claim as either not medically necessary, cosmetic, or an experimental investigational, you have 45 days from receipt of adverse determination to file an internal appeal with insurer. We strongly recommend that you undertake this action, as failure to do so will nullify your right to a possible External Appeal in the future. Instructions on how to initiate the internal appeal should have accompanied the notice of adverse determination. If you have already appealed internally and have received a final adverse determination, you have 45 days from receipt to request an External Appeal. The application form and instructions should have included with the final adverse determination notification.

NYS Department of Financial Services
Consumer Assistance Unit
25 Beaver Street New York, NY 10004
If you have more complaints to submit, use the appropriate option at the bottom of the page, either “New Complaint for this Company” which will populate the provider and the company information in a new form; or “New Complaint” which should be used if you are filing a complaint against a different insurer.

If you have questions, please contact us at consumers@dfs.ny.gov.