Consumer Assistance Process Form

Patient Information:
Date: _____
First Name: _____ **Middle Initial**: ____ **Last Name:** _____
Address:
Street: _____
City, State, Zip Code: _____
E-mail: _____

Hospital Name: _____
Hospital Date(s) of Service: _____
Have you contacted the Hospital? Yes ☐ No ☐
If yes, provide the name of contact person _____ and copies of any correspondence

Have you contacted any other State of Connecticut Agencies (i.e. Dept. of Insurance, Dept. of Public Health, and Office of Health Advocate)? Yes ☐ No ☐
If yes, provide the name of the contact person: _____and copies of any correspondence

Patient insurance, please check one: Commercial ☐ name: _____

Uninsured ☐ Medicaid ☐ Medicare ☐ Managed Care Medicare ☐ name: _____ Managed Care Medicaid ☐ name: _____

Did your insurance cover a portion of the bill? Yes ☐ No ☐

Do you have a formal payment plan arrangement with the Hospital? Yes ☐ No ☐

Bill status: In Collection: Yes ☐ No ☐

Provide a copy of your itemized Hospital bill (the line-item bill should outline every service provided, the date it was provided, and should include item and procedure codes) **and a description of your complaint with this form.**

Patient's signature: _____ **Date:** _____

If acting on behalf of the patient please indicate the following:

Name: _____ Relationship to the Patient: _____

Address: _____

Phone: _____
E-mail address (if available):_____

Signature: _____