

Complaint and Grievance Summary for Health Carriers

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Complete each table in this report based on complaints/grievances that were resolved (closed) in the calendar report year.

Filing is required for:
All commercial insurers, HMOs,
AFDS and BCBSM

2008
DUE
April 15, 2009

Bar Code Required - Place Bar Code Here

Name of Company	NAIC Group number and Company code	Filing company is (select only one):	<input type="checkbox"/> A commercial insurer
			<input type="checkbox"/> An HMO, AFDS or BCBSM

Instructions for Table 1: Do not report expedited reviews on this table.

Provide the number of Complaints/Grievances by decision for each level. If a health carrier has more than 3 levels of review, group them with level 3. If a health carrier does not have a level of review shown in the table, enter NA (for not applicable). Compile data based on the full calendar year.

For the purpose of this report, use Adverse Determination as defined in Section 550.1903(a) and Grievance as defined in Section 500.2213(5)(b) of the Insurance Code [BCBSM is Rule R550.101(e)].

Table 1	Grievances NOT resulting from adverse determinations or denials Please enter total number held at each level	Health Carrier position upheld	Health Carrier position overturned	Compromise resolution reached	Total Decisions made
		Level 1			
		Level 2			
		Level 3			
	Grievances resulting from adverse determinations or denials Please enter total number held at each level	Health Carrier position upheld	Health Carrier position overturned	Compromise resolution reached	Total Decisions made
		Level 1			
		Level 2			
Level 3					

How many grievances took longer than the statutory timeframe as provided in Section 500.2213 [BCBSM is Section 550.1404(2)(a)] of the Insurance Code to make a final written determination?



For each grievance that took more than the statutory timeframe to make a final written determination as provided in Section 500.2213(1)(k), [BCBSM is Section 550.1404(2)(a)], provide the following information: *(prepare a report that provides this data in the order given)*

- 1-1. Grievant's name
- 1-2. Date grievance was filed.
- 1-3. Date final decision was rendered.
- 1-4. Number of calendar days (excluding allowable tolled days) from date filed to render a final decision.
- 1-5. Summarize the reason(s) the statutory timeframe was exceeded.

Instructions for Table 2: Do not report expedited grievances. Do not report external reviews involving Medicaid, Medicare Supplement, or Medicare Advantage coverages. The "Grievance Terminated" column refers to external reviews terminated by the health carrier as a result of reconsideration by the health carrier. Section 550.1923(3) of the Insurance Code, the Patient's Right to Independent Review Act (PRIRA) requires each health carrier to annually report all requests for external review.

Table 2	External Reviews <i>Non-Expedited</i>	Health Carrier position upheld	Health Carrier position overturned	Compromise resolution reached	Grievance Terminated	Total Decisions made
	Total for reporting period					

Instructions for Table 3: Report only the number of Expedited Internal Reviews. Expedited grievances are defined in Section 550.2213(1)(l) [BCBSM is 550.1404(4)] of the Insurance Code

Table 3	Internal Reviews <i>Expedited</i>	Health Carrier position upheld	Health Carrier position overturned	Compromise resolution reached	Grievance Terminated	Total Decisions made
	Total for reporting period					

Instructions for Table 4: Do not report expedited grievances reviewed internally. Do not report external reviews involving Medicaid, Medicare Supplement, or Medicare Advantage coverages. Section 550.1923(3) of the Insurance Code, PRIRA requires each health carrier to annually report all requests for external review.

Table 4	External Reviews <i>Expedited</i>	Health Carrier position upheld	Health Carrier position overturned	Compromise resolution reached	Total Decisions made
	Total for reporting period				

ALL HEALTH CARRIERS:



Attach a self-generated report that summarizes and analyzes the categories, types and numbers of complaints and grievances, resulting from adverse and non-adverse determinations and external reviews addressed during the reporting year.

Certification

I certify that I am an officer of the company named in this report, and that I have authority to prepare and file this report. I have examined this report thoroughly, and it is true, complete and correct to the best of my knowledge and belief.

Signature of Officer		Date signed	Person and phone number to contact regarding this report
Signer's name and title typed or printed			
Signer phone number	Signer email address		Contact Person EMail address

PA 218 of 1956, PA 350 of 1983 and PA 251 of 2000, as amended requires submission of this form by all licensed health carriers. Failure to complete and submit this form properly could result in a compliance action or revocation of your authority to do business in Michigan.

Return completed report to Office of Financial and Insurance Regulation

By Mailing to: OFIR - Consumer Services
PO Box 30220
Lansing MI 48909-7720

By Delivery to: OFIR - Consumer Services
611 W Ottawa
Lansing MI 48933-1020

Commercial Insurers:

Address questions about this form to **Consumer Services** (517) 335-2059

HMOs, AFDS and Blue Cross Blue Shield of Michigan:

Address questions about this form to **Supervisory Affairs and Insurance Monitoring Division** (517) 241-2349



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