



0938-0948 (Expires 02/29/20)

Centers for Medicare & Medicaid Services

HIPAA ADMINISTRATIVE SIMPLIFICATION (NON-PRIVACY/SECURITY) COMPLAINT FORM

IMPORTANT: This form cannot be used for HIPAA Privacy or Security complaints. Please direct privacy/security complaints to the Office for Civil Rights at (800) 368-1019 or visit their website: www.hhs.gov/ocr/hipaa

If you have general questions regarding HIPAA, please consult the CMS website at www.cms.hhs.gov

SELECT COMPLAINT TYPE(S)

TRANSACTIONS

Select if a covered entity is in violation of the following transactions; claims and encounter information, payment and remittance advice, claims status, eligibility, enrollment and disenrollment, referrals and authorizations, coordination of benefits and premium payment.

CODE SETS

Select if a covered entity is in violation of the following Code Sets: HCPCS (Ancillary Services/Procedures), CPT-4 (Physicians Procedures), CDT (Dental Terminology), ICD-9 (Diagnosis and Hospital Inpatient Procedures), ICD-10 and NDC (National Drug Codes) codes with which providers and health plans are familiar. These are the adopted code sets for procedures, diagnoses, and drugs.

UNIQUE IDENTIFIERS

Select if a covered entity is in violation of the following Unique Identifiers: National Provider Identifier (NPI), or Employer Identification Number (EIN)

OPERATING RULES

Select if a covered entity is suspected of being in violation of any of the adopted Operating Rules: Eligibility for a Health Plan and Claims Status, and Electronic Funds Transfer and Remittance Advice.



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COMPLAINANT DETAILS

***Mandatory fields to be filled in**

Do you want to remain anonymous?*	<input type="radio"/> YES	<input type="radio"/> NO
If you select yes, please note CMS will not share information with the Filed Against Entity (FAE) during the investigation process. However, information provided in this complaint is subject to rules and policy under Freedom of Investigation Act (FOIA).		
Complainant Organization Name*:		
Complainant Organization Type:		
Complainant Organization Role:		
Complainant Organization Phone Number*:		
Complainant Title*:		
Complainant First Name*:		
Complainant MI:		
Complainant Last Name*:		
Complainant Address Line 1*:		
Complainant Address Line 2:		
Complainant City/Town*:		
Complainant State/Territory*:		
Complainant Zip Code*:		
Complainant Email Address*:		
Complainant Contact Phone Number*:		
Complainant Cell Phone Number:		



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FILED AGAINST ENTITY (FAE) DETAILS

***Mandatory fields to be filled in**

FAE Organization Name*:

FAE Organization Type:

FAE Organization Role:

FAE Contact Title*:

FAE Contact First Name*:

FAE Contact MI:

FAE Contact Last Name*:

FAE Address Line 1*:

FAE Address Line 2:

FAE City/Town*:

FAE State/Territory*:

FAE Zip Code*:

FAE Contact Email Address:

FAE Contact Phone Number*:



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COMPLAINT DETAILS

*Mandatory fields to be filled in

- **Non-Compliant HIPAA Transaction Received** - You received a non-compliant HIPAA transaction from a covered entity
 - **Compliant Transaction Sent and Rejected** - A covered entity rejected your compliant HIPAA transaction.
 - **Invalid Companion Guide** - A covered entity that you send data to or receive data from requires use of a non-compliant companion guide. For example, a companion guide must not specify additional fields beyond those specified by the adopted standard.
 - **Code Set Received or Sent and Rejected** - Either or both of these examples may apply: (1) A covered entity sent you a non-compliant HIPAA code within an electronic transaction. (2) A covered entity rejected a compliant HIPAA code that you sent within an electronic transaction.
 - **Failure to Conduct a Standard Transaction** – A covered entity failed to conduct a standard transaction.
 - **Other** - You have another type of complaint against a covered entity. Please describe below:
-



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COMPLAINT DETAILS

***Mandatory fields to be filled in**

Incident Occurred Date*: Ex. [2/27/2017]	
Complaint Subject*:	
Complaint Description*:	
Complaint Transaction Type:	
Attempted To Resolve:	
Complainant Action Description:	
Complaint Previously Submitted:	Yes/No (circle)



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TRANSACTION TYPE

- None
- 270 - Eligibility, Coverage or Benefit Inquiry
- 271 - Eligibility, Coverage or Benefit Information
- 276 - Healthcare Claim Status Request
- 277 - Healthcare Claim Status Notification
- 278 - Healthcare Services Review - Request to Review
- 278 - Healthcare Services Review - Response Request to Review
- 820 - Payment Order - Remittance Advice
- 834 - Benefit Enrollment and Maintenance
- 835 - Healthcare Claim Payment / Advice
- 837 - Healthcare Claim - Institutional
- 837 - Healthcare Claim - Dental
- 837 - Healthcare Claim - Professional
- NCPDP Retail Pharmacy Transactions

Please sign and date this complaint.	
SIGNATURE:	DATE:
PRINTED NAME:	
<p>Filing a complaint with CMS is voluntary. However, without the information requested on the complaint form, CMS may be unable to proceed with the complaint. CMS collects this information under authority of 68 FR 60694 (October 23, 2003) issued pursuant to the HIPAA. CMS will use the information provided to determine if CMS has jurisdiction and, if so, how CMS will process the complaint. Information submitted on the complaint form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed only when it is necessary for investigation of possible HIPAA A.S. Non-privacy violations, for internal systems operations, or for routine uses, which include disclosure of information outside the Department for purposes associated with HIPAA A.S. Non-Privacy compliance and as permitted by law. To submit an electronic complaint, go to https://asett.cms.gov/</p>	

PRA Disclosure Statement

In accordance with the Paperwork Reduction Act (1995), no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-0948 (Expires 02/29/20). The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, Maryland 21244-1850 Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. ***CMS Disclosure*** Any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact: Cecily Austin at cecily.austin@cms.hhs.gov or Geanelle Herring at Geanelle.herring@cms.hhs.gov .