



Centers for Medicare & Medicaid Services (CMS)



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

COMPLAINT TYPE

***Must select one of the following:**

- ☐ **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 (As of October 1, 2015) and NDC (National Drug Codes) codes with which providers and health plan are familiar, are the adopted code sets for procedures, diagnoses, and drugs.
- ☐ **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
- ☐ **Operating Rules** - Select if a covered entity is suspected of being in violation of any of the adopted Operating Rules: Electronic Funds Transfer/Electronic Remittance Advice (EFT/ERA), Health Care Claim Status, and Eligibility for a Health Plan.
- ☐ **Unique Identifiers** - Select if a covered entity is in violation of the following Unique Identifiers:
National Provider Identifier (NPI), Employer Identification Number (EIN).



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COMPLAINANT DETAILS

***Mandatory fields to be filled in**

Do you want to remain anonymous? * ☐ YES ☐ 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:	
Complaint Organization Type (Other)	
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 Type (Other)	
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**

Incident Occurred Date*:	Ex. [2/27/2017]
Complaint Subject*:	
Complaint Description*:	
Complaint Transaction Type:	
Does the complaint relate to the FAE charging fees to conduct standard transactions?*	
Have you previously attempted to resolve this complaint?	Yes/No
If yes, describe the action you took to resolve this complaint.	
Has this complaint been previously submitted?	Yes/No



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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:	
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/ASETT_HomePage	
During the course of an investigation, NSG may need to request additional information from the complainant to investigate the complaint's allegations. In the event of such a request, it will be sent from HIPAAComplaint@cms.hhs.gov. When providing a response to NSG, please ensure that your response does not contain Protected Health information (PHI) or Personally Identifiable Information (PII), or send your response containing PHI or PII in an encrypted file, with the decryption key sent in separate email.	