



CHARLIE CRIST  
GOVERNOR

HOLLY BENSON  
SECRETARY

Dear Consumer:

Please return your complaint form to:  
Agency for Health Care Administration  
Complaint Administration Unit  
2727 Mahan Drive, Mail Stop# 49  
Tallahassee, FL 32308

The Agency for Health Care Administration is able to intervene on behalf of consumers having communication and billing problems with Florida hospitals and other health care entities. Charges for individual services are not controlled or approved by the Agency, nor do we have the authority to determine if a facility has overcharged a patient, or to modify a payment schedule. However, we are able to intervene and ask the facility to audit your bill if you feel you have been charged for services you did not receive and you feel the facility has been unresponsive to your requests. If possible, please supply the dates and who you spoke to at the Billing Office along with your complaint form. We ask that you contact the facility to attempt to resolve your concerns prior to sending in your complaint form.

The enclosed complaint form must be completed, signed, and returned to us, along with a copy of your itemized bill and any other documentation you feel may be important. It is helpful if you can be as specific as possible as to your precise complaint. Perhaps you have had difficulty receiving an itemized statement or a refund for overpayment, or there are items on your bill, which you believe are incorrect, such as being charged for services or supplies you do not recall receiving, or being charged twice for a procedure.

Upon receipt of your completed complaint form, an analyst will review your concerns. If there is an issue our office is able to address, we will write to the Chief Executive Officer or Administrator of the facility and will ask that your concerns be addressed within thirty days. It will be requested that they respond directly to you and furnish a copy to us. All decisions made by the facility are final unless additional information is provided that would show reason to ask the facility to look at your issues again.

If you should need to contact the agency regarding your complaint, please do not hesitate to do so by calling 1-888-419-3456, and request to speak to the Complaint Administration Unit.

Thank you.





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## CONSUMER BILLING COMPLAINT FORM

This form is to be used ***ONLY*** for billing issues associated with Florida hospitals, laboratories and other health care facilities. If there are medical or health care related issues, **DO NOT COMBINE THEM ON THIS FORM.**

Mr.  Mrs.  Ms.

Patient Name:

\_\_\_\_\_ Last First Middle Initial

Address:

\_\_\_\_\_ Street City State Zip Code

Daytime Telephone #: ( ) \_\_\_\_\_ Second Telephone #: ( ) \_\_\_\_\_

Hospital/Facility Name:

\_\_\_\_\_

Address:

\_\_\_\_\_ Street City State Zip Code

Type of Complaint:  Billing error  Itemized bill not received  Billing practices  
Type of Insurance:  HMO  PPO  Indemnity  Other

Was the patient an:  Outpatient  Inpatient  Emergency Room

Hospital Account #(s) \_\_\_\_\_ Date(s) of Service: \_\_\_\_\_

Balance owed: \$ \_\_\_\_\_

Have you contacted the hospital/facility to try and correct this situation?  Yes  No

Date of Contact(s) \_\_\_\_\_

Hospital/Facility person(s) talked with: \_\_\_\_\_

What has been done to investigate your complaint? \_\_\_\_\_

Are you represented by an attorney?  Yes  No

AHCA Form 1000-2004A, February 2008

2727 Mahan Drive, MS#49  
Tallahassee, Florida 32308



Visit AHCA online at  
<http://ahca.myflorida.com>

