





Centers for Medicare & Medicaid Services (CMS)  
Office of HIPAA Standards (OHS)



## HIPAA Non-Privacy Complaint Form

**IMPORTANT:** The information requested in the remainder of this form is optional. However, any additional information you provide will assist OHS in the enforcement process.

### OPTIONAL INFORMATION

**Have you filed this complaint with another agency? If so, please provide us with the following:**

<b>Agency Name:</b>	<b>Agency Contact Person:</b>
<b>Date the Complaint was Filed:</b>	<b>Contact Number:</b>
<b>Complaint Identification Number:</b>	

**Please provide OHS with more detail about this complaint.**

<p>1. <b>Please describe yourself.</b></p> <p><input type="checkbox"/> Health Plan</p> <p><input type="checkbox"/> Covered Health Care Provider (<i>See examples on the right</i>)</p> <p><input type="checkbox"/> Health Care Clearinghouse</p> <p><input type="checkbox"/> Patient or representative of the patient</p> <p><input type="checkbox"/> Other: _____</p> <p>2. <b>Who are you filing this complaint against?</b></p> <p><input type="checkbox"/> Health Plan</p> <p><input type="checkbox"/> Covered Health Care Provider (<i>See examples on the right</i>)</p> <p><input type="checkbox"/> Health Care Clearinghouse</p> <p>3. <b>Have you attempted to resolve the dispute?</b></p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p>	<p><b><u>Examples of Covered Health Care Providers:</u></b></p> <p>Ambulance Service</p> <p>Comprehensive Outpatient Rehabilitation Facility</p> <p>Durable Medical Equipment Service</p> <p>Home Health Agency</p> <p>Hospice Program</p> <p>Hospital / Critical Access Hospital</p> <p>Non-Physician Practitioners</p> <p>Outpatient Physical or Occupational Therapy</p> <p>Physician</p> <p>Rural Health Clinics and Federally Qualified Health Centers</p> <p>Skilled Nursing Facility</p>
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**For a Transactions and Code Sets Complaint (Check the appropriate box.)**

**Non-Compliant 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 uses of a non-compliant companion guide. For example, a companion guide must not specify additional fields beyond those specified by HIPAA.

**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.

**Other** - You have another type of complaint against a covered entity.

**Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0948**. 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: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



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**For a Transactions and Code Sets Complaint (Check the appropriate box.)**

1. Check the appropriate transaction(s) discussed in your complaint. Note: If your complaint involves a transaction(s) that is not listed, you may not have a valid transaction complaint.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> 270 Eligibility, Coverage or Benefit Inquiry     | <input type="checkbox"/> 837 Health Care Claim: Dental          | <input type="checkbox"/> 835 Health Care Claim Payment/Advice                             |
| <input type="checkbox"/> 271 Eligibility, Coverage or Benefit Information | <input type="checkbox"/> 837 Health Care Claim – Professional   | <input type="checkbox"/> 820 Payment Order/Remittance Advice                              |
| <input type="checkbox"/> 276 Health Care Claim Status Request             | <input type="checkbox"/> 837 Health Care Claim: Institutional   | <input type="checkbox"/> 278 Health Care Services Review - Request for Review             |
| <input type="checkbox"/> 277 Health Care Claim Status Notification        | <input type="checkbox"/> 834 Benefit Enrollment and Maintenance | <input type="checkbox"/> 278 Health Care Services Review - Response to Request for Review |
| <input type="checkbox"/> NCPDP Retail Pharmacy Transactions               | <input type="checkbox"/> I don't know                           |   |

2. Check the appropriate code set(s) discussed in your complaint.

- |  |  |
|--|--|
| <input type="checkbox"/> International Classification of Diseases, 9 <sup>th</sup> Edition, Clinical Modification (ICD-9-CM) | <input type="checkbox"/> Healthcare Common Procedure Coding System (HCPCS) |
| <input type="checkbox"/> Common Procedure Terminology (CPT)  | <input type="checkbox"/> National Drug Code (NDC)                          |
| <input type="checkbox"/> Codes on Dental Procedures and Nomenclature - Current Dental Terminology (CDT)                      | <input type="checkbox"/> Other: _____                                      |

**For a Security Complaint (Check the appropriate box.)**

Do you believe that personal health information was wrongfully shared or disclosed, or that the action you are complaining about otherwise violated the health information Privacy Rule?

- YES  
 NO

**Mail completed forms to: Centers for Medicare & Medicaid Services  
HIPAA TCS Enforcement Activities  
P.O. Box 8030  
Baltimore, Maryland 21244-8030**

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