Harbor Health
Member Complaint Form

To start the complaint process, the member must complete this Complaint Form and mail it to:

Harbor Health Insurance Company
Attn: Complaints
P.O. Box 211262
Eagan, MN 55121

Member Information

Member Name (Please Print)		Member ID Number
Member's Street Address		
City	State	Zip Code

Reason for your complaint (Check all that applies):

- ☐ Accessibility/Availability of Medical Services
- ☐ Balance Billing
- ☐ Claims Processing or Claim Denial (for reasons other than not medically necessary)
- ☐ Complaint Procedures
- ☐ Member Service
- ☐ Group Subscriber Contracts
- ☐ Marketing
- ☐ Network Provider Unavailability
- ☐ Physician/Provider Contracts
- ☐ Provider Directory Accuracy
- ☐ Quality of Care or Quality of Services
- ☐ Reimbursement Amount
- ☐ Utilization Review or Management Processes
- ☐ Other

Provide any details or facts that you feel should be considered in our review of your complaint, such as your provider's name and address, claim number, dates of service, or medical information. Please use additional pages if necessary and attach any supporting documentation that you have.

Signature and Submission

I acknowledge that the information contained within this form is accurate to the best of my knowledge. I have provided complete and accurate information upon which to base an investigation of the circumstances surrounding the issue. I agree to cooperate and provide any additional information necessary and/or appropriate related to this complaint. My failure to do so may result in Harbor Health closing the investigation into this matter.

Member Printed Name	**Date**
Member Signature	