

How to Use the DFS Provider Complaint Forms Portal

<https://www.dfs.ny.gov/complaint>

In order to use the online Provider Complaint Forms application on the Department of Financial Services (DFS) portal, healthcare providers or their staff need to set up an account in the DFS portal.

Healthcare providers should use the Provider Complaint Forms application to file a complaint with DFS about health or no fault claims. Filing in the portal will allow the provider to obtain a file number immediately upon submitting the complaint. You will have the option to include supporting documents when you file the complaint, and additional information can be added to an existing complaint any time after filing the initial online complaint. Providers can view open and closed complaint files in the portal. Closed complaints will be available for 6 months after the file is closed. Providers must not use the Consumer Complaint application to submit complaints.

Before Filing

You must first attempt to resolve this issue with the insurer before filing a complaint with DFS. You will need to provide details (dates, times, contacts, etc.) about how you attempted to resolve this with the insurer. Otherwise, the case will be closed upon receipt.

Starting a new complaint

After selecting Provider Complaint Forms under My Applications, click “File a Provider Complaint”. (See Figure 1)

Once you start to enter a complaint, you will have 30 minutes to submit it. See below for the information required for each complaint. We recommend that you have this information available prior to starting the process. If the complaint is not submitted within 30 minutes, the information will be lost, and you will need to restart the complaint. (See Figure 2)

When completing the complaint form, any field in the portal with an asterisk (*) is a required field. You will not be able to advance to the next screen until all required fields are completed.

There are five tabs to complete for each complaint:

- Provider
- Complaint Details
- Patient
- Supporting Documentation
- Review/Submit

Figure 1

Department of Financial Services | Consumer Information | Applications & Filings | Industry Guidance | Reports & Publications | Contact Us

DFS Portal | My account | Sign Out

My Apps | Application | Get Access

Provider Complaints

Applicant Information

Which best describes you? Provider Representative

Provider Complaints

File a Provider Complaint

Please note that the New York State Workers' Compensation Board (WCB) provides assistance to providers with respect to unpaid medical claims pursuant to New York State Workers' Compensation Law. In view of the assistance available to you by the WCB, we will not be handling this complaint type. Please visit the following webpage for information about how to request assistance from the WCB.
<http://www.wcb.ny.gov/content/main/hcpp/request-assistance-unpaid-medical-bills.jsp>

If the Case is Closed, a closing letter will follow. Please allow 5-7 business days from Closed Date.

Case List Export to Excel

	Case# ↑↓	Date Submitted ↑↓	Status ↑↓	Closed Date ↑↓	Dispute Code ↑↓	Patient ↑↓	Respondent ↑↓	Service Provider ↑↓	Date of Service ↑↓	Examiner ↑↓
Add Info	CSB-2024-01584546	03/30/2024	CLOSED	04/01/2024 08:16:26	ING	Submission 2, Test		Daigneault, Mark	03/01/2024	

Figure 2

Department of Financial Services | Consumer Information | Applications & Filings | Industry Guidance | Reports & Publications | Contact Us

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Applicant Information

Which best describes you? Provider Representative

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If the Case is Closed, a closing letter will follow. Please allow 5-7 business days from Closed Date.

Case List Export to Excel

You must click Submit with 30 minutes of launching the online complaint form

OK

	Case# ↑↓	Date Submitted ↑↓	Status ↑↓	Closed Date ↑↓	Dispute Code ↑↓	Patient ↑↓	Respondent ↑↓	Service Provider ↑↓	Date of Service ↑↓	Examiner ↑↓
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Provider Tab (see Figure 3)

Information on the Provider tab will pre-populate from the user's account. You can change any of the information that pre-populates. This is information about the provider or provider's business. You should not enter information about the patient or insurance company on this screen.

Figure 3

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DFS Portal

My Apps Application Get Access

Provider Complaints

Provider Complaint Details Patient Supporting Documentation Review/Submit

Provider Information

Business Name:

and/or *

First Name:

Middle Name:

Last Name:

Title:

Address 1: *

Address 2:

City: *

State: *

Zip: *

Phone: *

Extension:

Fax:

Email #1: *

Email #2:

Email #3:

Tax ID: *

(If different than the Person named above)

Name of Person who provided Services:

Title of Person who provided Services:

Next →

Complaint Details Tab (two types) (see Figure 4)

For What is your Complaint Type? (this relates to the type of insurance), use the drop-down box to select the type of complaint you are filing:

- No Fault (this is used only if the services relate to an automobile accident)
- ***Prompt Pay (this is used for health insurance complaints)***

Complaint Details Tab – Prompt Pay

Use this option to file a complaint regarding health insurance claims.

- Who is the person/entity you are complaining about? – Use the Insurance Company drop down box to select the name of the insurance company about which you are submitting the complaint. If the company you are complaining about is not listed, check the box and then enter all of the available information about the insurance company.
- Are you a participating provider with the health plan? – Indicate Yes or No if you have a provider agreement with the insurance company indicated above.
- Does this matter involve a health claim denied as not medically necessary, or that the services are experimental or investigational? – Indicate Yes only if you or the patient received an Initial Adverse Determination or Final Adverse Determination that denied the claim as not medically necessary or experimental or investigational, otherwise indicate No.
- Have you attempted to resolve this with the insurer? and Comments - provide the details (dates, times, contacts, etc.) of how you attempted to resolve this with the insurer.
- Date(s) of Service (DOS) and Billing Code – you can enter multiple dates of service for the same patient even if the dates were entered on separate claims. Do not file multiple complaints with this Department for additional dates of service for the same patient. Use the “Add Additional DOS” button to add more than one date of service. You can enter more than one billing code per date of service by clicking Add Billing Code.
- Comment Box: Provide any other details about the complaint, such as the payment was denied and for the reason for the denial; if the payment was underpaid even though there was an agreement for payment; ;if the services were pre-authorized (provide the authorization number); etc.

Figure 4 (initial blank screen; the fields will change after you select Complaint Type – Prompt Pay)

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DFS Portal

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Provider Complaints

Provider **Complaint Details** Patient Supporting Documentation Review/Submit

Complaint Description

What is your Complaint Type? *

Is this complaint related to COVID-19? * Yes No

Case Information

Policy Number:

Date of Accident: *

Have you attempted to resolve this with insurer? * Yes No

Comments: *

Date(s) of Service

Date of Service : *

Date Claim Submitted: *

Billing Code: * Ext: Amount: *

Add Billing Code

Add Additional DOS If you have additional Dates of Service for the complaint/patient, please click this button to add the dates. Do not file a separate complaint for additional dates of service

← Back **Next →**

Figure 4 (completed for Prompt Pay)

Complaint Description

What is your Complaint Type? *

Is this complaint related to COVID-19? * Yes No

Who is the person/entity you are complaining about?

Select the Insurance Company
from this menu. If the company you are complaining about is not in this menu, check this box

Insurance Company: *

Case Information

Are you a participating provider with the health plan? Yes No

Does this matter involve a health claim denied as not medically necessary, or that the services are experimental or investigational? * Yes No

Have you attempted to resolve this with insurer? * Yes No

Describe how you attempted to resolve this issue with the insurer: *

Comments: *

Date(s) of Service

Date of Service : *

Date Claim Submitted: *

Was the claim submitted electronically to the company? * Yes No

Billing Code: * Ext: Amount: *

If you have additional Dates of Service for the complaint/patient, please click this button to add the dates. Do not file a separate complaint for additional dates of service

Figure 4 (when the insurance company is not in the drop-down box)

Provider	Complaint Details	Patient	Supporting Documentation	Review/Submit
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Complaint Description

What is your Complaint Type? * Prompt Pay ▼

Is this complaint related to COVID-19? * Yes No

Who is the person/entity you are complaining about?

Select the Insurance Company from this menu. If the company you are complaining about is not in this menu, check this box

Business Name:

First Name:

Last Name:

Address 1:

Address 2:

City:

State: New York ▼

Zip:

Phone:

Email:

Patient Tab (see Figure 5)

- Enter the name and address of the patient related to the claim listed on the Complaint Details tab.
- Patient ID – the insurance company’s identification number for this patient

Figure 5

My Apps **Application** Get Access

Provider Complaints

Provider Complaint Details **Patient** Supporting Documentation Review/Submit

Patient Information

First Name: *	<input type="text" value="John"/>
Middle Name:	<input type="text"/>
Last Name: *	<input type="text" value="Doe"/>
Address 1: *	<input type="text" value="Address"/>
Address 2:	<input type="text"/>
City: *	<input type="text" value="City"/>
State: *	<input style="border: none; border-bottom: 1px solid #ccc; padding: 2px 5px; display: inline-block; vertical-align: middle;" type="text" value="New York"/> ▼
Zip: *	<input type="text" value="55555"/>
Patient ID: *	<input type="text" value="ABC1234"/>

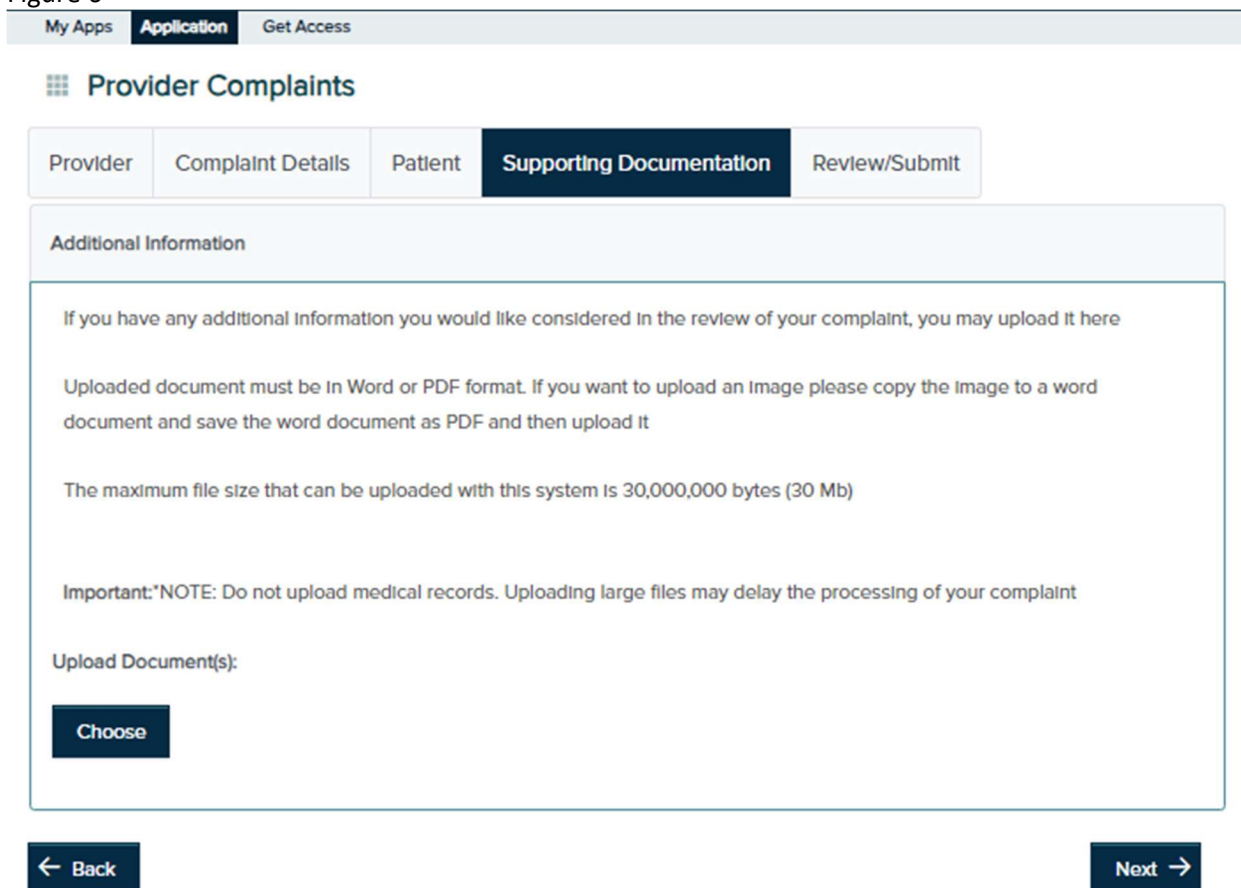
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Supporting Documentation Tab (see Figure 6)

Uploaded documents must be in Word or PDF format. If you want to upload an image, please copy the image to a word document and save the word document as PDF and then upload it. You also have the option to upload documents, after you submit the complaint. The maximum file size that can be uploaded with this system is 30,000,000 bytes (30 Mb). Uploading large files may delay the processing of your complaint.

Do NOT upload medical records.

Figure 6



Review/Submit Tab (see Figure 7)

You have the ability to review your complaint before submitting it to DFS. Use the Back button on the bottom of the screen to edit information on any previous screens. You must click the box next to "I Agree", before you can submit the complaint. The system will assign a file number once you submit the complaint. You can print your submission for your records. Additional information or documents can be added to the complaint after you submit it.

Figure 7

Provider	Complaint Details	Patient	Supporting Documentation	Review/Submit
<p>Please review before submitting. If you wish to make any changes, click the Back button to return to previous screens.</p> <p><u>This case will not be processed until you press the Submit button at the bottom of this screen.</u></p>				
Provider				
Business Name:	TEST			
First Name:	Mark			
Middle Name:				
Last Name:	Daigneault			
Title:				
Address 1:	adr			
Address 2:				
City:	cyt			
State:	NY			
Zip:	66666-6666			
Phone:	(777) 777-7777			
Extension:				
Fax:				
Email #1:	mark.daigneault@dfs.ny.gov			
Email #2:				
Email #3:				
Tax ID:	22-2222222			
Name of Person who provided services:				
Title of Person who provided Services:				
Patient				
First Name:	John			
Middle Name:				
Last Name:	Doe			
Address 1:	Address			
Address 2:				
City:	City			
State:	NY			
Zip:	55555			
Patient ID:	ABC1234			

Case Information

What is your Complaint Type? Prompt Pay
Is this complaint related to COVID-19? No
Insurance Company: Aetna Better Health
Are you a participating provider with the health plan? No
Does this matter involve a health claim denied as not medically necessary, or that the services are experimental or investigational? No
Have you attempted to resolve this with insurer? Yes
Describe how you attempted to resolve this issue with the insurer: list dates, times and people contacted when attempting to resolve this issue
Comments: Provide any relevant comments here

Date(s) of Service

DOS List

Date Of Service	Date Claim Submitted	Submitted Electronically	Billing Code List
01/09/2024	01/19/2024	Yes	

• Billing Code: 88888.G56 Amount: \$100.00

Total Amount: \$100.00

In order to resolve your complaint we may send a copy of this form and any supporting documentation you submit to the person or firm you are complaining about.

In filing this complaint, I understand that the Department of Financial Services is not my private attorney, but represents the public in enforcing laws designed to protect the public from misleading or unlawful business practices. I also understand that if I have any questions concerning my legal rights or responsibilities, I should contact a private attorney. I have no objection to the contents of this complaint (including supporting documentation) being forwarded to the institution or person that the complaint is directed against. The above complaint is true and accurate to the best of my knowledge.

I Agree:

You must 'Agree' before continuing

[← Back](#)

Figure 7 (after I Agree is checked)

In order to resolve your complaint we may send a copy of this form and any supporting documentation you submit to the person or firm you are complaining about.

In filing this complaint, I understand that the Department of Financial Services is not my private attorney, but represents the public in enforcing laws designed to protect the public from misleading or unlawful business practices. I also understand that if I have any questions concerning my legal rights or responsibilities, I should contact a private attorney. I have no objection to the contents of this complaint (including supporting documentation) being forwarded to the institution or person that the complaint is directed against. The above complaint is true and accurate to the best of my knowledge.

I Agree:

You must 'Agree' before continuing

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[Submit](#)

Your case has been successfully submitted to NYSDFS. Your case number is [CSB-2024-01587598](#)

If you wish to save or print a copy of your submission, please click the [Save a Copy](#) button before leaving this screen.

[Save a Copy](#)

[Start New Case](#)