

Department of Health and Human Services
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Electronic Health Care Transactions and Code Sets Complaint Submission Form

You may use this form to file a HIPAA complaint. This form is for the submission of complaints about covered entities that are not compliant with the HIPAA electronic health care transactions and code set standards. This form should not be used to file complaints regarding the privacy of health information.

If you choose, you can now file on-line at <http://cms.hhs.gov/hipaa/hipaa2/default.asp>. Or you may mail your complaint to the following address:

HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Section A: Your Contact Information (person or entity filing the complaint)

First Name: _____ Middle Initial: ____ Last Name: _____
Title: _____ Organization: _____
Street Address Line 1: _____
Street Address Line 2: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: _____ Extension: _____
Email Address: _____

Section B: Information about the Entity that you are filing a complaint about

Name of Covered Entity: _____
Tax Identification Number: _____ Medicare Identification Number: _____
Type of Covered Entity (Check one)
 Health Care Clearinghouse
 Health Plan
 Health Care Provider (choose one)
 Dentist
 DME Supplier
 Home Health Agency
 Hospice
 Hospital
 Nursing Home
 Pharmacy
 Physician/Group Practice
 Other
Covered Entity Contact Person:
First Name: _____ Middle Initial: ____ Last Name: _____
Title: _____
Street Address Line 1: _____
Street Address Line 2: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: _____ Extension: _____

