HEALTH CONNECTOR FRAUD COMPLAINT FORM

Complaint registered against:

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Office Number: _____

Person filing the complaint:

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Daytime phone number where you can be reached: _____

Relationship to this person, if not you: _____

People who may have perpetuated the fraud against you or are witnesses to it.

Please list any names, addresses and phone numbers of anyone who you allege was involved in this fraud or has knowledge of it.

PERSON	NAME	ADDRESS	PHONE NUMBER	DATE OF OCCURRENCE (MM/DD/YYYY)
1				
2				
3				

Please provide all relevant details to this complaint.

Other complaints filed

Have you or the person allegedly discriminated against filed a complaint about this matter with any other agency or organization?

☐ Yes ☐ No

If yes, please identify the name and location of the office(s) where the complaint was filed.

When was the complaint filed? (MM/DD/YYYY): _____

Your signature

We cannot accept a complaint if it has not been signed. Please sign (electronically or by hand) and date this complaint form below:

Signature: _____ Date: _____

Signature: _____ Date: _____

Note: If you are filing the complaint for someone else, you must also get that person to sign and date it.

How to file this complaint

Send a completed, signed and dated copy of all pages of the Health Connector's Non-Discrimination Complaint Form and any supporting documentation you want us to see, to:

Mailing Address: Attn: Compliance Manager
Massachusetts Health Connector Compliance Unit
P.O. Box 960189
Boston, MA 02196

Email Address: HCReport@state.ma.us

OPTIONAL SECTION

The remaining information on this form is optional. Not answering these does not affect the Health Connector's investigation into your complaint.

Special accommodations

Do you need special accommodations for us to communicate with you about this complaint?
(Check all that apply):

☐ Braille ☐ Large Print ☐ CD with Word file ☐ Audio CD ☐ Electronic Mail ☐ TDD

☐ Sign language interpreter (specific language): _____

☐ Foreign language interpreter (specify language): _____

☐ Other (specify): _____

Ethnicity and language preference

To help us better serve the public; please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

Ethnicity (select one):

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Ethnicity (select all that apply):

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American ☐ White

☐ Other (specify): _____

Preferred Language (if other than English): _____