



SHAWNSTEEL
— LAW FIRM —

MED PAY COLLECTION KIT

Three Easy Steps:

1. **Demand Letter:**

Send a 'demand' letter on your stationary with a deadline. See attached. Especially important is to always have your patient co-sign the letter. This educates patients and motivates them. It also sends a powerful message to the 1st Party Med Pay Carrier that their own insured is making a personal demand on them – not merely the doctor.

2. **Department of Insurance [DOI] Complaint:**

The day following the Demand letter's deadline. Complete the DOI form and have the patient sign the complaint. The patient will be further engaged with payment of their own bill.

The insurance companies do not welcome complaints from the DOI. Be sure to send copies of the complaint to the adjuster and their supervisor.

3. **Small Claims Lawsuit:**

California's generous small claims jurisdiction permits suits up to \$10,000 if you are an individual or a sole proprietor. Corporations and other entities are limited to \$5,000. In addition, a party (individuals or corporations) can file no more than two claims exceeding \$2,500 in any court throughout the State of California during a calendar year.

But, once again, you need to have your patient agree to serve as a co-plaintiff against their own insurance company. You can't sue by yourself with only an Assignment of Benefits.

The insurance company cannot bring their attorneys. The claims manager and the adjuster can represent the insurance company if you name them as defendants.

If your patient does not care to cooperate, then they immediately qualify to pay the difference owed by their own insurance company to you.

HOWARD FIGHTBACK, DC
8383 Wilshire Boulevard #640
Beverly Hills, CA 90021

VIA CERTIFIED MAIL

Auto Insurance Co.
Attn: Jane Smith, Med Pay Representative
1234 Main St., Suite A
Pleasanton, CA 90001

**RE: DEMAND FOR FULL MED PAY BENEFITS DUE AND PAYABLE
IN SEVEN DAYS**

Your Insured/Our Patient : William Victim
Your Claim No. : 02011655A
Date of Accident : 11/19/2015

Dear (name of Med Pay representative):

We understand that Auto Insurance Company is declining full coverage for our patient's Med Pay benefits. As Auto Insurance Company is aware, this denial is contrary to the requirements of the Insurance Code and the rules promulgated by the Department of Insurance. Your company maintains that due to my contract limitations with Landfill Managed Care, that Auto Insurance Company is not obligated to reimburse the full balance of my unpaid reasonable and customary bills.

This position is contrary to law and the contract requirements of Landfill Managed Care.

Please see the attached section of the relevant portions of the applicable contract which specifically states that the reduction of benefits is NOT applicable in a personal injury case. Moreover, this contract specifically exempts the participating physician for having to limit his or her reasonable and customary fees for personal injury cases.

Therefore, we demand the following:

Immediately pay the balance due to this office within seven days from the date of this letter. Failure to honor Auto Insurance Company's duty bound and legal obligation to your insured will compel our patient to file a grievance with the Department of Insurance.

Additionally, we will file jointly with our patient a court action against Auto Insurance Company. Moreover, should we prevail in court, then Auto Insurance Company should certainly anticipate a Bad Faith First Party action.

RE: DEMAND FOR FULL MED PAY BENEFITS DUE AND PAYABLE IN SEVEN DAYS, PAGE 2

Very truly yours,

NOTE: Both the patient and the doctor should sign this letter to show the unity of the parties, making the correspondence much more powerful.

(signature of doctor)

Howard Fightback, DC

(signature of patient)

William Victim

CC: William Victim

Encl.: Copy of relevant portion of Landfill Managed Care contract

DEPARTMENT OF INSURANCE

CONSUMER SERVICES AND MARKET CONDUCT BRANCH

CONSUMER SERVICES DIVISION

300 SOUTH SPRING STREET, SOUTH TOWER

LOS ANGELES, CA 90013

www.insurance.ca.gov

CSD-001-P

Revised: 04/11/2014



REQUEST FOR ASSISTANCE (RFA)

Name _____ Daytime Phone: () _____

Address _____ Alternate Phone: () _____

City /Zip _____ Email address: _____

=====
Name of the policyholder if different from your name: _____

Type of Insurance: Auto Home Life/Annuity Long-Term Care Other _____

Complete name of insurance company involved: _____

Policy number: _____ Claim number: _____

Date loss occurred or began (if applicable): _____

Insurance Broker/Agent (if applicable): _____ Broker/Agent License Number: _____

Broker/Agent Phone Number: _____ *Broker/Agent Email Address:* _____

Broker/Agent Street Address: _____ *City/State:* _____ / _____ *Zip:* _____

Have you contacted the company, agent or broker? Yes No

If yes, state the date(s) and person(s) contacted: _____

Have you reported this to any other governmental agency? Yes No

Name of Agency: _____

Date Reported: _____ *Case Number* _____



RFA

Have you previously written to the Department of Insurance about this matter? Yes No

File number (if available) _____ Date _____

Are you represented by an attorney in this matter? Yes No

Has a lawsuit been filed? Yes No

Is the case currently in active litigation? Yes No *If yes, we will defer the regulatory investigation until the finality of the litigation. We ask that you still complete this form so we have a record of your issue. Once the matter is concluded, we would welcome any information regarding violations of insurance law by the insurer that you or your attorney are willing to provide.*

Briefly, describe your problem (use additional paper if needed):

What do you consider to be a fair resolution to your problem?

In order for us to effectively begin our investigation, please provide any supporting documentation you may have related to this matter along with your *Request for Assistance (RFA)*.

- Supporting documentation (i.e. copies of correspondence between you and the insurance company/broker-agent; declaration page of your insurance policy; canceled checks; letters of claim denial, etc.)
- If you wish to give authority to someone to assist you in filing this *Request for Assistance (RFA)*, please complete the *Authorization and Designation of Agent* form.

PLEASE READ:

I understand that a copy of this form and all documentation submitted will be provided to the licensee involved in this Request for Assistance.

(Signature)

(Date)

**State Of California
Department of Insurance
Authorization and Designation of Agent**

- If you want to give someone the authority to assist you in the filing of your complaint please fill in Parts A and B below.
- If you are a parent or legal guardian filing this complaint for a child under the age of 18, you do not need to complete this form.
- If you are filing a complaint for a consumer who cannot complete this form and you have legal authority to act for this consumer, please complete Part B only. Also send a copy of the power of attorney for health care decisions or other legal document that says you can make decisions for the consumer.

PART A: COMPLAINANT

I allow the person named below in Part B to assist me in completing a complaint filed with the California Department of Insurance (CDI). I allow the CDI to share my personal information with the person named below in Part B. This may include information about my medical condition(s) and care if applicable and may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want it to end, I must do so in writing.

Name of Complainant (Print) _____

Complainant Signature _____ Date _____

PART B: PERSON ASSISTING THE COMPLAINANT

If Applicable, Name of Organization (Please print)

Name of Person Assisting (Please print)

Signature of Person Assisting _____

Address _____

Relationship to Complainant

Daytime Phone # _____ Evening Phone # _____

My Power of Attorney for health care decisions or other legal document is attached.

Return the completed form to California Department of Insurance, Consumer Services Division, 300 S. Spring Street, Los Angeles, CA 90013. If you have any questions, the Department can be reached at (800) 927-4357, Outside of California (213) 897-8921.



Privacy Notice on Information Collection

Request for Assistance Forms

*** This notice is provided pursuant to the Information Practices Act of 1977 (California Civil Code Section 1798.17) ***

Collection and Use of Personal Information

California Insurance Code Sections 12921 and 12921.1, and related statutes and regulations, give the California Department of Insurance (CDI) and the Consumer Services Division the authority to regulate and investigate consumer complaints. The CDI uses your information to address complaints brought to the Department's attention. Information is collected subject to limitations contained in the Information Practices Act of 1977, SAM 5300, et seq., SIMM 5305, et seq., and other applicable state and federal laws.

Providing Personal Information is Voluntary

You do not have to provide the personal information requested. However, if you do not wish to provide us the necessary information, we may not be able to investigate your complaint. When providing information or documents, please do not include unrequested personal information, such as Social Security Numbers, Driver's License Numbers, unnecessary health-related information, and credit card or financial information.

Possible Disclosure of Personal Information

We may share your personal information with the insurance licensee and in the case of an Independent Medical Review with the Independent Medical Review Organization. We may also share your information with other government agencies as required by law.

Access to Your Information

You have the right to access records containing your personal information which are maintained by CDI. To request access, contact: CDI Privacy Officer, Legal Division, Government Law Bureau, 300 Capitol Mall, Suite 1700, Sacramento, CA 95814, (916) 492-3800.

Department Privacy Policy

The California Department of Insurance has developed policies regarding the privacy of your information. They may be viewed at www.insurance.ca.gov/privacy-policy.