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. It's especially important to 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.

JohnTawlian@shawnsteel.com | (800) 626-0003

Beverly Brighter, DC
Chiropractic Clinic
143 Arizona Street, Malibu, CA 90542
Office: 310-777-1234 | Fax: 310-777-1235
Email: bbchirodc@nomail.com

Today's Date

Via Certified Mail

Insurance Company
Address 1
Address 2
Attn: Adjuster, Claim no. ##

RE: DEMAND FOR MED PAY PAYMENT; DUE IN 7 DAYS BY 5 PM

Our Patient	**: Lisa Anyman**
Your Insured	**: Daniel Anyman**
Your Claim No.	**: 123-456-AB**
Date Accident	**: 02-01-2019**

Dear Mr./Ms. Adjuster:

On behalf of our patient, *LISA ANYMAN*, we demand that *INSURANCE COMPANY* make immediate payment of the legitimate fees charged to our patient, your insured. We are sure that you are familiar with the Insurance Code Section 790.03 which requires *INSURANCE COMPANY*'s good faith when dealing with its own insured.

Unfortunately, *INSURANCE COMPANY* has failed to provide appropriate protection in order to pay fair and proper medical fees. *INSURANCE COMPANY*'s last letter reducing payment is without excuse or justification. Therefore, we inform you that, along with our patient, we will be forced to file a formal complaint against *INSURANCE COMPANY* within seven [7] days from the date of this letter to the Department of Insurance [DOI].

In addition, we will be forced to file suit against *INSURANCE COMPANY* for full tender of our legitimate and reasonable medical fees.

We prefer not to take these measures. But *INSURANCE COMPANY*'s unilateral action leaves us and our patient without any further choices. We trust *INSURANCE COMPANY* will take the reasonable approach and pay the rest of the benefits due to our patient, your insured.

Sincerely,

_____ _____

Dr. Beverly Brighter **Lisa Anyman: Patient and Insured**

STATE OF CALIFORNIA Ricardo Lara, *Insurance Commissioner*

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: 01/07/2019

REQUEST FOR ASSISTANCE (RFA)

Name_____ Daytime Phone: ( ) _____

Address _____ Alternate Phone: ( ) _____

City /Zip _____ Email address: _____

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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 # _____ Email Address _____

☐ 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.

DEPARTMENT OF INSURANCE

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.

Information Provided to CDI Is Confidential

All information you provide to us during the investigation of your complaint will be treated as a confidential communication under California Insurance Code Section 12919. We will not disclose any information to any person outside CDI, unless otherwise permitted or required by law.

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 or regulatory agencies as permitted or required by law, or pursuant to Memorandum of Understanding.

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) 492-3500.

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.