Oscar Complaint Form - New Jersey

Completion of this form is optional. However, we encourage the form's return to assist in resolving your complaint. To file a complaint, you or your authorized representative may contact our Member Services Department using the telephone number displayed on the member ID card or submit a letter in writing to the address listed below. Oscar will mail a written acknowledgement within 15 days from the date of receipt and a second written response within 30 calendar days from the date of receipt with resolution.

1. Member Information

*If you are filling this form out on behalf of **multiple Members**, please indicate that below and include a separate page with all of the requested information for each additional Member. If you are filling this form out on behalf of **all Members in a Group**, please indicate that below and be sure to include the Group ID #.*

Member Name: _____

Member ID #: OSC_____ Group ID # (if applicable): BIZ_____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Date of Birth _____

2. Complainant Information (if different from Member)

*If you are **not** the Member, please provide **your** information here.*

Your Name: _____

Company: _____

Relationship to Member:

❏ Parent ❏ Spouse ❏ HR Administrator ❏ Broker

❏ Other: _____

Your Mailing Address: _____

City: _____ State: _____ Zip: _____

Your Phone Number: _____ Your Fax Number: _____

oscar

3. Please describe the nature of your complaint below (please use additional pages if necessary). Add any facts your feel should be considered in the review of your complaint. As a reminder, please attach any supporting documentation you have.

If your complaint involves a claim, please additionally provide the following (if available):

Claim ID(s): _____ Date(s) of Service: _____

Provider(s) and/or Facility Name(s): _____

4. Did you speak with an Oscar representative about this issue?

___NO ___YES - If yes, please provide the name of the individual that you spoke to and the date:

Name of Rep(s): _____ Date(s): _____

If no, you may be able to resolve your issue immediately by contacting Oscar at 1-855-672-2755 or help@hioscar.com.

5. Authorization (if submitted by someone other than the Member)

Please note that Oscar is unable to share a Member's Personal Health Information (PHI) without the express written permission of the Member via a HIPAA authorization form. Please contact Oscar or visit hioscar.com/forms to get a copy of the HIPAA authorization form, which must be completed and signed by the Member.

Has the Member(s) signed a HIPAA authorization form authorizing you to speak on the Member's behalf?

___ NO ___YES

If we do not have a HIPAA authorization on file, the written response for a complaint filed by a non-authorized party will be mailed to the Member.

Would you like us to send the response to you instead? ___ NO ___YES

If YES, Oscar will contact the Member to request they authorize you to receive this information.

6. Signature and Submission

I acknowledge that the information contained within this form is accurate to the best of my knowledge. I have provided complete and accurate information upon which to base an investigation of the circumstances surrounding the issue. I agree to cooperate and provide any additional information necessary and/or appropriate related to this complaint. My failure to do so may result in Oscar closing the investigation related to this matter.

Signature _____ Date _____

Name (Printed): _____

Please submit this completed form (Attn: Complaints) to one of the following:

By mail:
Oscar Garden State Insurance Corp
Attn: Complaints
P.O. Box 52146
Phoenix AZ, 85072

By email:
help@hioscar.com
Attn: Complaints

By fax:
888-977-2062
Attn: Complaints