Wellmark Advantage Health Plan, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.

# HEALTH CARE PRIVACY COMPLAINT FORM

Use this form to file a complaint regarding Wellmark Advantage Health Plan regarding our privacy policies, procedures and practices, or compliance with our Notice of Privacy Practices or state and federal privacy rules and laws. You do not waive your state and federal privacy rights by filing a complaint. Furthermore, filing a complaint will not influence your treatment, payment, enrollment or eligibility for benefits. We will not retaliate against you for filing a complaint.

**Section A: Individual filing complaint**

| LAST NAME | | FIRST NAME | | INITIAL |
|---|---|---|---|---|
| DATE OF BIRTH (MM/DD/YYYY) | | DATE OF INCIDENT | | |
| ADDRESS | | CITY | STATE | ZIP |
| EVENING PHONE NUMBER | DAYTIME PHONE NUMBER | CONTACT HOURS (Please specify when you prefer to be called) | | |

Insured's information (Person whose name appears on the ID card)

| LAST NAME | FIRST NAME | INITIAL |
|---|---|---|
| ENROLEE ID NUMBER (From your ID card) | | |

**Section B: Complaint**

Please give a simple, concise explanation of the complaint:

**Section C: Signature**

I certify that the statements made in this complaint are true and correct to the best of my information and belief.

_______________ *Signature* _______________ *Date*

*If the complaint is lodged by a personal representative on behalf of the individual, complete the following and check the appropriate box.*

**Print name of personal representative:** _______________

**Signature of personal representative and date:** _______________

☐ Parent of minor child ☐ Legal guardian ☐ Power of attorney ☐ Executor ☐ Other

Please return this form to: **The Privacy Office**
**600 East Lafayette, MC 1302**
**Detroit, MI 48226-2998**

| Processors Information (For internal use only) | |
|---|---|
| NAME (please print): | PHONE NUMBER |
| SIGNATURE | DATE |