Complaint Form

Office of the Civil Rights Coordinator

Please use this form to submit a complaint about an alleged discriminatory action.

COMPLAINANT INFORMATION		
Last Name	First Name	Middle Initial
Street Address (Line 1)		
Street Address (Line 2)		
City	State	
ZIP	Phone Number	
Email		
Are you filing this complaint for someone else? ◯ Yes ◯ No		
Last Name	First Name	
If yes, whose civil rights do you believe were violated?		

COMPLAINT DETAILS					
I believe that I have been (or someone else has been) discriminated against on the basis of:					
◯ Race/Color/National Origin	◯ Age	◯ Religion	◯ Sex	◯ Disability	
◯ Other (specify)					
Who or what organization do you believe discriminated against you (or someone else)?					
Person or Organization					
Street Address (Line 1)					
Street Address (Line 2)					
City	State				
ZIP	Phone Number				
When do you believe the civil right discrimination occurred?	Date / /				

SUM3734-1P (5/25)

COMPLAINT DETAILS

Briefly describe what happened. How and why do you believe that you have been (or someone else has been) discriminated against? Please be as specific as possible. (Attach additional pages as needed)

OPTIONAL INFORMATION

The information in this section is optional. Failure to answer these voluntary questions will not affect CareFirst's decision to process your complaint.

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

◯ Braille ◯ Large Print ◯ Cassette Tape ◯ Computer Disc (CD) ◯ TDD

◯ Email

◯ Sign language interpreter (specify language)

◯ Foreign language interpreter (specify language)

◯ Other

If we cannot reach you directly, is there someone we may contact to reach you? If yes, please provide the following:

Name	Phone number or email

Please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing)

Ethnicity:

◯ Hispanic or Latino ◯ Not Hispanic or Latino

Race:

◯ American Indian or Alaska Native ◯ Asian ◯ Native Hawaiian or other Pacific Islander

◯ Black or African American ◯ White ◯ Other (specify):

Primary language spoken (if other than English):

PLEASE SIGN

Filing a complaint with CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. (CareFirst) is voluntary. However, without the information requested herein, CareFirst may be unable to proceed with your complaint. We collect this information under authority of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and other civil rights statutes. We will use the information you provide to determine whether we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses which include disclosure of information outside of CareFirst for purposes associated with civil rights compliance and as permitted by law.

You are not required to use this format. You may write a letter or complaint with the same required information indicated herein.
To submit a complaint, please mail, fax or email all documentation related to this complaint to:

Office of the Civil Rights Coordinator
CareFirst BlueCross BlueShield
P.O. Box 14858
Lexington, KY 40512
Fax: 410-505-2011
Email: civilrightscoordinator@carefirst.com

After reading the above information, please check **ONLY ONE** of the following circles:

- ◯ **AGREE:** I have read, understand and agree to the above.
- ◯ **DECLINE:** I have read and understand the above, but I do not agree with it.

Printed Name	Date / /
Signature	

PLEASE SIGN THIS COMPLAINT CONSENT

CareFirst has the authority to collect and receive material and information about you, including personal and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, CareFirst may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows CareFirst to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, CareFirst may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA).

Under FOIA, CareFirst may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

In order to expedite the investigation of your complaint if it is accepted by CareFirst, please read, sign, and return one copy of this consent form to CareFirst with your complaint. Please make one copy for your records.

As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for CareFirst to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.

I am also aware of the obligations of CareFirst to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for CareFirst to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

After reading the above information, please check ONLY ONE of the following boxes:

- ◯ **CONSENT:** I have read, understand, and agree to the above and give permission to CareFirst to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of CareFirst's investigation, conciliation, or enforcement process.
- ◯ **CONSENT DENIED:** I have read and I understand the above and do not give permission to CareFirst to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Printed Name	Date / /
Signature	

To submit this form, please mail, fax, or email all supporting documents, such as copies of letters or denials from the insurance company, medical records, or any other records you think are important to:

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CareFirst BlueCross BlueShield
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Lexington, KY 405124
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Email: civilrightscoordinator@carefirst.com