First MEDICAL HEALTH PLAN, INC.

Civil Rights Discrimination Complaint Form

Use this form to file a Civil Rights Discrimination Complaint. You may submit your complaint by addressing it to the Corporate Compliance Department, PO Box 191580, San Juan, PR 00919-1580 or by emailing alertacumplimiento@firstmedicalpr.com.

You may also submit a complaint to the U.S. Department of Health and Human Services Office for Civil Rights via e-mail at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail to U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201. You may also obtain a claim form from DHHS at http://www.hhs.gov/ocr/office/file/index.html.

I. Subscriber/Beneficiary/Claimant Institution Information		
First Name:	Middle Name:	Last Name:
Mailing Address:		Plan Identification Number:
Residence Phone Number:	Cell Phone Number:	Email Address: ☐ I authorize FMHP to send information to my email in a secure (Encrypted) manner.

II. How can we contact you?					
☐ Phone	☐ Email	☐ Postal	☐ TTY	☐ Braille	☐ Sign Language Interpreters

III. Are you filing this Complaint on behalf of someone else? ☐ **Yes** ☐ No

If yes, who is the person whose health information privacy rights appear to have been violated?

First Name: Last Name:

IV. I believe I have been (or someone else has been) discriminated against because of:

☐ Race/ Color/ Nationality ☐ Age ☐ Religion ☐ Conscience ☐ Sex
☐ Gender Identity ☐ Disability ☐ Others: (Specify) _____

V. Description of your Complaint

a. General Information

Name of Organization/Institution/Person against whom your claim is against:

When did the events occur?

b. Details of Claim

Provide a detailed description of your claim, including who, what, where when and why. If you wish to attach supporting documentation, please ask a Customer Service Representative for assistance.

Do you have witnesses? ☐ Yes ☐ No If you have witnesses, please provide the name and phone number of your witness(es):	
Witness 1	Witness 2
Name:	Name:
Phone Number:	Phone Number:
Have you filed your claim elsewhere? If yes, please provide us with the following information. (Attach additional sheets as needed	
Date Case Filed:	Claim/Case Number:
First Medical Health Plan, Inc., may decide that your claim does not violate your rights or any other applicable law or regulation, but perhaps another organization can help you. Please choose one of the following: ❑ ***I agree to have this claim disclose with another organization.*** ❑ ***I do not agree to have this claim disclose to another organization.***	
VI. **Signature**	
I certify that the information on this form is true and correct to the best of my knowledge, information and belief. Signature:	Date:

This information is available free of cost in other languages. For additional information please contact our Privacy Unit number at (787) 474-3999, ext. 2108, 2583. We are available Monday thru Friday from 8:30 am to 5:00 pm.

The information provided on this form is confidential and is protected by the provisions set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Names or other information about individuals will be disclosed as necessary for purposes of investigating possible breaches of health information privacy, for internal systems operations or routine uses, including disclosure for health information privacy compliance purposes and as permitted by law. It is unlawful for any covered entity to intimidate, threaten, coerce, discriminate, or retaliate against you for filing this complaint. You are not required to use this form to file a complaint. You may also write a letter or file your complaint electronically with the requested information. To file a complaint electronically, write to us at: alertacumplimiento@firstmedicalpr.com.