



Filing an Appeal or Complaint Online

USER GUIDE

DECEMBER 2025

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What is an Appeal or Complaint?

There are several reasons why an enrollee may be dissatisfied with a decision made by their health maintenance organization (HMO). The issue may be simple or complex and may relate to past, current or future health care claims. If you have been denied coverage, believe your access to providers is limited or are dissatisfied with how you have been treated or served - you have options.

There are four types of complaints or appeals that the Minnesota Department of Health (MDH) can help you with, listed below. When you submit your appeal or complaint online, MDH will review the information you provide and can recommend the best option for you.

- **External Appeal:** You disagree with a coverage decision made by your HMO, and you have already filed an appeal with your HMO that was denied. External appeals are reviewed by an Independent Review Organization (IRO); the decision made by the IRO is final. External appeals must be filed within 6 months of the date your appeal with your HMO was denied.
- **HMO Complaint:** You disagree with a decision made by your HMO, or how you were treated. MDH will investigate your complaint. You do not need to file an appeal with your HMO before filing a complaint.
- **No Surprises Act complaint:** The No Surprises Act, a federal law, may protect you from some types of surprise bills, including balance billing, or problems with a good faith estimate you received from a provider. These complaints may be about your health plan or a health care provider.
- **Quality of Care complaint:** The Minnesota Department of Health reviews complaints about quality of care you received from your health plan or its contracted medical providers. Quality of care issues may involve concerns about a provider's knowledge or skill, behavior, attitude, diagnosis, and treatment. You will not receive the final resolution of this type of complaint.

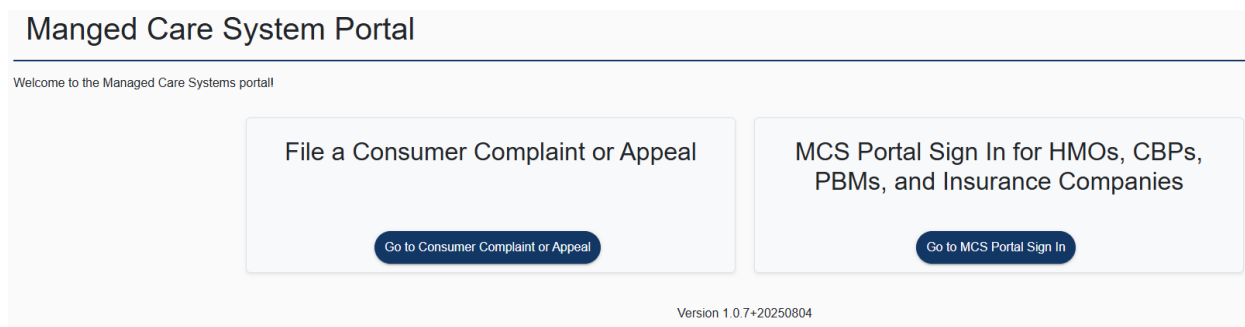
For more information on the different types of complaints and appeals, visit our website, which includes frequently asked questions: [HMO Enrollee External Appeals and Complaints \(https://www.health.state.mn.us/facilities/insurance/managedcare/complaint/index.html\)](https://www.health.state.mn.us/facilities/insurance/managedcare/complaint/index.html).

This guide will walk you through the process of filing a complaint or appeal online through the Managed Care Systems Portal (MCS Portal). No login or account is required to file an appeal or complaint online.

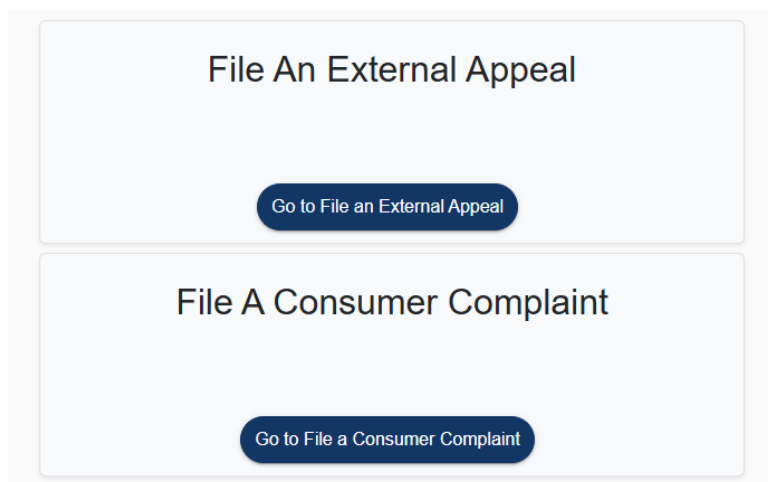
Accessing the Complaints and Appeals Section

1. Go to the Portal [Managed Care System Portal \(mcs-portal.web.health.state.mn.us\)](https://mcs-portal.web.health.state.mn.us)

Click on “File a Consumer Complaint or Appeal”



Select whether you want to file a complaint or an appeal:



Instructions for filing an external appeal are on page 4, instructions for filing a consumer complaint are on page 10. You do not have to login or create an account to file an appeal or complaint online.

Filing an External Appeal

File An External Appeal

[Go to File an External Appeal](#)

1. The first page you come to provides information about the appeal process, and what will happen with the information you provide.

MDH is providing this fillable form in order to collect information from you about why you are filing an external appeal, HMO complaint, No Surprises Act complaint, or quality of care complaint. MDH intends to use the information you provide for investigation of your appeal or complaint, which may include collecting information from your HMO and provider(s), and, for external appeals only, delivering the data you provide to an Independent Review Organization that has contracted with MDH to review external appeals (“IRO”).

- You are not legally required to provide any data to MDH and you may refuse to provide data. However, if you do not provide the requested data, no investigation or review will occur and no action will take place with respect to your appeal or complaint.
- If you provide the requested data, your data will be used by MDH to investigate your complaint or by an IRO to review your external appeal. Data you provide may also be used in an action MDH brings against an HMO.
- The data you provide may be disclosed to MDH staff whose job(s) requires them to access the appeal or complaint material, Independent Review Organizations who have contracted with MDH to review external appeals, other Minnesota state agencies that have legal authorization to obtain the data, the Minnesota Attorney General’s office, the state or legislative auditor, or to anyone MDH is directed by court order.

2. Click “next” after reading the information to show you understand it.

[Next](#)

3. Complete the Patient Information section, which provides information about the patient, and the patient’s address.

Patient Information

First Name (required) <input type="text" value="Jane"/>	Middle Name <input type="text" value="Middle Name"/>	Last Name (required) <input type="text" value="Doe"/>
Date of Birth (required) <input type="text" value="01/01/1980"/>	Phone Number <input type="text" value="(612) 555-4444"/>	Email <input type="text" value="jane.doe@fakemail.com"/>

How are you related to the patient? (required)

Select Relationship
▼

Self

Spouse

Parent

Guardian

Health Care Provider

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- a. If you are the patient, indicate your relationship as “self”
- b. If you are not the patient, select your relationship to the patient. You will then fill out the “authorized representative information.”

Authorized Representative

Your Name (required)	Your Primary Phone Number	Your Email Address
<input type="text" value="Jack Doe"/>	<input type="text" value="(612) 555-4444"/>	<input type="text" value="jack.doe@fakemail.com"/>

Patient Address

Street (required)		
<input type="text" value="123 Main Street Apartment 2"/>		
City (required)	State (required)	Zip Code (required)
<input type="text" value="Wilmar"/>	<input type="text" value="MN"/>	<input type="text" value="56201"/>

4. Add in health plan information. Please include your HMO and insurance ID (from your health insurance card). If you know the type of coverage you have, please include that information. If you aren't sure, you can leave it blank.

Health Plan Information

Health Insurance Company (required)	Patient Insurance ID (required)
<input type="text" value="HealthPartners"/>	<input type="text" value="MN55512574"/>
Type of Coverage	
<input type="text" value="Select Coverage Type"/>	
<div>Group (Employer) Coverage</div> <div>Individual (MNSure)</div> <div>PMAP/Medical Assistance</div> <div>MinnesotaCare</div> <div>Medicare</div>	

5. Provide information about your appeal.
 - a. Type out the summary of your appeal. You have 3000 characters to write why you are appealing. If you want to upload a document describing your appeal instead of typing it, simply write “Document describing the appeal attached.”

Summary of Appeal (required)

I called my health plan before I went to get my MRI, and they told me I didn't need a prior authorization. Now my health plan denied the claim and said I do need a prior authorization. I appealed and they still won't cover it.

- b. You can also attach documents, such as referrals, denials, prior authorizations, bills, explanations of benefits, screen shots, and any other information that will help the Independent Review Organization (IRO) review your appeal. It is not necessary to upload documents, but you may not have the opportunity to provide additional information to the IRO once your appeal is submitted.

Supporting Documents

If possible, attach copies of any relevant documents such as referrals, denials, prior authorizations, bills, explanations of benefits, screen shots, and any other information that will help the Independent Review Organization (IRO) review your appeal. It is not necessary to upload documents, but you may not have the opportunity to provide additional information to the IRO once your appeal is submitted.


- A statement describing the appeal.
- Statements and/or letters of medical necessity from your healthcare provider(s)
- A copy of the most recent denial letter from your insurer. Any supporting documents (e.g., medical records, test results, etc.)

Microsoft Word, PDF, Jpeg, and PNG files are allowed.

☐ I don't have anything to upload.

+ Choose

Drag and drop files here or select choose above.
The selected file will be automatically renamed and uploaded.

- Drag and drop files into the upload box, or click on "choose" to select files from your computer.
- The upload box allows word, PDF, jpg and png files.
- The upload box will automatically add additional information to your file name.
- The upload box will have an orange box that says "pending" while the file is being uploaded; for larger files you will see a grey horizontal bar indicating the status of the upload, that will turn blue as the document is uploading.
- You can upload multiple files.
- Click on the  to remove all files and start over.

+ Choose

...view Tool PY2025 06142024.pdf 22.698 MB	Pending	✕
...761078168995_Appeal-de.docx 13.024 KB	Completed	✕
..._1761078200898_CloudDriv.pdf 124.14 KB	Completed	✕

- c. If you do not have files to upload, check the “I don’t have anything to upload” box located above the uploader. The upload will disappear.

☒ I don't have anything to upload.

Information About Your Appeal

- i. **WARNING: If you check this box after uploading files, all the files you uploaded will be deleted.**
6. Provide additional preferences about your appeal in the “Information About Your Appeal” section.
- a. The internal appeal status is whether or not you have already appealed the decision internally at your HMO. If you do not know, that is ok, we will check with your HMO.

Information About Your Appeal

MDH will review your information and evaluate whether an investigation should be conducted. Please provide necessary information. Please indicate if any of the below apply:

Internal Appeal Status (required)

Select Internal Appeal Status

I have filed an appeal with my HMO

I have NOT filed an appeal with my HMO

I don't know

- i. If you have filed an appeal with your HMO, please enter the date your appeal was denied. If you aren’t sure, that is ok.

Internal Appeal Status (required)	Internal Appeal Denial Date
<div>I have filed an appeal with my HMO</div>	<div>MM/DD/YYYY</div>

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- b. MDH will review your information and evaluate whether an investigation should be conducted before filing the external appeal. If MDH believes an investigation should be conducted first, we will contact you directly to discuss the process. If you do not want to consider a complaint instead of an appeal, check the box “I only want to file an external appeal”, circled below.

Information About Your Appeal

MDH will review your information and evaluate whether an investigation should be conducted before filing an external appeal. If MDH believes an investigation should be conducted, we will contact you directly to discuss our investigation process and obtain any necessary information. Please indicate if any of the below apply:

Internal Appeal Status *(required)*

Select Internal Appeal Sta... ▼

- ☐ I only want to file an external appeal. I understand that if I file an appeal, the decision reached by the independent review organization (IRO) is final and MDH cannot investigate my complaint afterwards.

- c. A normal appeal can take 45 days. If you believe a 45 day wait could harm your health, or the health of the person you are representing, you may request an expedited appeal 72-hour appeal pursuant to Minnesota law. Check the box if you would like to expedite your appeal.



☐ I would like to expedite my appeal (Additional information required).

- i. Your health care provider will need to agree that your appeal should be expedited. Often, a provider is the person filing the expedited appeal. Please complete the information with your provider's name, phone number, and address. If you have the name of a contact person, and the provider email, give that information as well.

A normal appeal can take 45 days. If you believe a 45-day wait could harm your health, or the health of the person you are representing, you may get an expedited 72-hour appeal pursuant to Minnesota Statute 62Q.73, Subd. 6. (e) (1).

☒ I would like to expedite my appeal (Additional information required).

Provider Information

Name *(required)*

Provider Name

Representative

Provider Representative/Contact Pers

Provider Phone Number *(required)*

Provider Phone Number

Provider Email Address

Provider Email

Provider Address

Street *(required)*

Street

City *(required)*

City

State *(required)*

State

Zip Code *(required)*

Zip Code

- ii. This information is **only** required for expedited appeals.

7. Indicate if MDH can forward your appeal to the appropriate state agency if MDH does not have jurisdiction over your appeal. If MDH does not have jurisdiction, we will let you know. Responding that you authorize MDH to forward your appeal means you will not have to submit it again if MDH does not have jurisdiction.

Forwarding Authorization

If it is determined that the external appeal does not fall under the jurisdiction of MDH, we may share your external appeal with another state agency.

Forwarding Authorization (required)

Select an Answer

I authorize MDH to forward my external appeal to the appropriate state agency.

I DO NOT authorize MDH to forward my external appeal to the appropriate state agency.

8. Sign your appeal.
 - a. Please read the information carefully before signing. By typing your name in the signature field, you are electronically signing this form; your electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Statutes, Chapter 325L.07)
 - b. The date will fill in automatically

Signature (required)

Date

Your Full Name

10/21/2025

- c. If you are filing an appeal for someone else, you will also need to enter your relationship to the patient.

Signature (required)

Date

Your Full Name

10/21/2025

Relationship to Patient (required)

Relationship

9. Click "Submit Appeal"

Submit Appeal

Filing a Consumer Complaint

File A Consumer Complaint

[Go to File a Consumer Complaint](#)

1. The first page you come to provides information about the complaint investigation process, and what will happen with the information you provide.

MDH is providing this fillable form in order to collect information from you about why you are filing an external appeal, HMO complaint, No Surprises Act complaint, or quality of care complaint. MDH intends to use the information you provide for investigation of your appeal or complaint, which may include collecting information from your HMO and provider(s), and, for external appeals only, delivering the data you provide to an Independent Review Organization that has contracted with MDH to review external appeals (“IRO”).



- You are not legally required to provide any data to MDH and you may refuse to provide data. However, if you do not provide the requested data, no investigation or review will occur and no action will take place with respect to your appeal or complaint.
- If you provide the requested data, your data will be used by MDH to investigate your complaint or by an IRO to review your external appeal. Data you provide may also be used in an action MDH brings against an HMO.
- The data you provide may be disclosed to MDH staff whose job(s) requires them to access the appeal or complaint material, Independent Review Organizations who have contracted with MDH to review external appeals, other Minnesota state agencies that have legal authorization to obtain the data, the Minnesota Attorney General’s office, the state or legislative auditor, or anyone MDH is directed by court order to provide it to.
- Per MN Statutes Section 62D.115, Quality of Care complaints are classified as confidential data on individuals or protected nonpublic data as defined in MN Statutes Section 13.02, subdivision 3 or 13, and results cannot not be disclosed, even to subjects of the complaint.

[Next](#)

2. Click “next” after reading the information to show you understand it.
3. Complete the Patient Information section, which provides information about the patient, and the patient’s address.

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Patient Information

First Name (required)	Middle Name	Last Name (required)
<input type="text" value="Jane"/>	<input type="text" value="Middle Name"/>	<input type="text" value="Doe"/>
Date of Birth (required)	Phone Number	Email
<input type="text" value="01/01/1980"/> 	<input type="text" value="(612) 555-4444"/>	<input type="text" value="jane.doe@fakemail.com"/>
How are you related to the patient? (required)		
<div>Select Relationship </div> <div><div>Self</div><div>Spouse</div><div>Parent</div><div>Guardian</div><div>Health Care Provider</div></div>		

- If you are the patient, indicate your relationship as “self”
- If you are not the patient, select your relationship to the patient. You will then fill out the “authorized representative information.”

Authorized Representative



Your Name (required)	Your Primary Phone Number	Your Email Address
<input type="text" value="Jack Doe"/>	<input type="text" value="(612) 555-4444"/>	<input type="text" value="jack.doe@fakemail.com"/>

Patient Address

Street (required)		
<input type="text" value="123 Main Street Apartment 2"/>		
City (required)	State (required)	Zip Code (required)
<input type="text" value="Wilmar"/>	<input type="text" value="MN"/>	<input type="text" value="56201"/>

- Add in health plan information. Please include your HMO and insurance ID (from your health insurance card). If you know the type of coverage you have, please include that information. If you aren’t sure, you can leave it blank.

Health Plan Information

Health Insurance Company (required)	Patient Insurance ID (required)
<div>HealthPartners </div>	<input type="text" value="MN55512574"/>
Type of Coverage	
<div>Select Coverage Type </div> <div><div>Group (Employer) Coverage</div><div>Individual (MNSure)</div><div>PMAP/Medical Assistance</div><div>MinnesotaCare</div><div>Medicare</div></div>	

- Provide a summary of your complaint.

- a. Type out the summary of your complaint. You have 3000 characters to explain your complaint. If you want to upload a document describing your appeal instead of typing it, simply write “Document describing the complaint attached.”

Summary of Complaint

Summary of Complaint (required)

My health plan used to cover my drug, and all of a sudden in the middle of the year, they stopped covering it. When I called and asked, they said they changed what they covered during the year, and I need a new drug instead. I have been on this drug for 10 years.

265 / 3000 characters used

- b. You can also attach documents, such as referrals, denials, prior authorizations, bills, explanations of benefits, screen shots, written correspondence with your HMO or provider, and any other information that you think will be helpful to the investigators.

Supporting Documents

If possible, attach copies of any relevant documents such as referrals, denials, prior authorizations, bills, explanation of benefits, screen shots, and written correspondence with your HMO or provider that are relevant to your consumer complaint. For example, you can upload:

- A statement describing the complaint.
- Statements and/or letters of medical necessity from your healthcare provider(s)
- A copy of the most recent denial letter from your insurer. Any supporting documents (e.g., medical records, peer-reviewed studies, photos, etc.)

Upload Option (Word, PDF, jpeg, Png, jpg) for the consumer to upload as many as documents needed (Limit to 20 files and 250 MB)


☐ I don't have anything to upload.

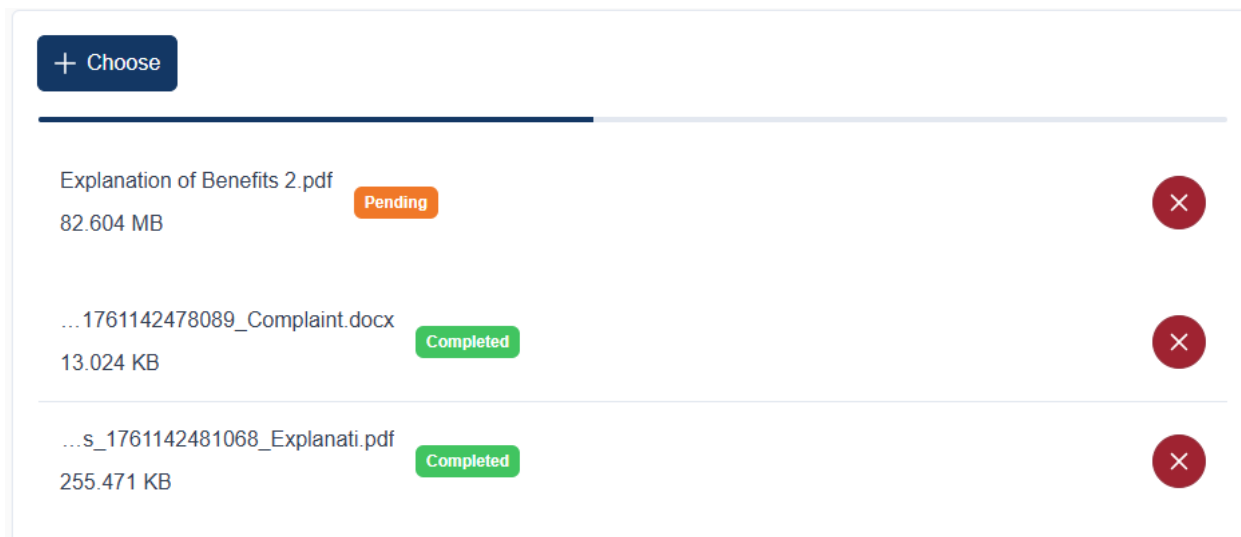
+ Choose

Drag and drop files here or select choose above.
The selected file will be automatically renamed and uploaded.

- i. Drag and drop files into the upload box, or click on “choose” to select files from your computer.
- ii. The upload box allows word, PDF, jpg and png files.
- iii. The upload box will automatically add additional information to your file name.

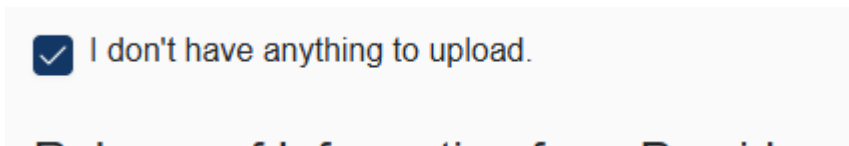
Online Appeal or Complaint User Guide

- iv. The upload box will have an orange box that says “pending” while the file is being uploaded; for larger files you will see a grey horizontal bar indicating the status of the upload, that will turn blue as the document is uploading.
- v. You can upload multiple files.
- vi. Click on the  to remove all files and start over.



File Name	Size	Status	Action
Explanation of Benefits 2.pdf	82.604 MB	Pending	
...1761142478089_Complaint.docx	13.024 KB	Completed	
...s_1761142481068_Explinati.pdf	255.471 KB	Completed	

- c. If you do not have files to upload, check the “I don’t have anything to upload” box located above the uploader. The upload will disappear.



☒ I don't have anything to upload.

- i. **WARNING: If you check this box after uploading files, all the files you uploaded will be deleted.**

- 6. Provide a release of information from health care providers.
 - a. MDH may need to contact your providers for information on services you received, your health, and interactions they may have had with your HMO that are related to your complaint. By signing this form and submitting your complaint, you are giving MDH permission to contact and obtain information from the providers you list.
 - i. Include the name, phone number, and the time period, or dates of service, that are relevant to your complaint.

Release of Information from Providers

MDH may need to contact your providers related to your complaint. Providers may include clinics, physicians, hospitals, pharmacies, and any other provider that may have protected health information (PHI) relevant to your complaint. For each provider you list, please indicate the dates of service, or time period, that is relevant to your complaint. By signing this form and submitting your complaint, you are giving MDH permission to contact and obtain information from your providers.

Provider 1

Name

Provider Phone Number

Date of Service From

Dr. Smith

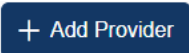
(651) 777-8888

08/11/2025

Date of Service To

08/31/2025

+ Add Provider

- ii. If you have more than one provider, click the  button; you may add multiple providers.

7. There are different types of complaints. MDH reviews all complaints and may suggest that you file an external appeal if the information you provide needs a medical opinion. Please indicate if you believe your complaint fits into any of the categories under “Type of Complaint;” you may select all that apply.

Type of Complaint

There are different types of complaints that can be filed with MDH. MDH will review whether your concern can be handled as a complaint or if it involves a denial that

If your issue involves a denial that needs a medical opinion, it may be handled as a complaint by the Internal Review Organization (IRO) that uses clinical experts.

Please indicate below if any of the following apply to your complaint:

- ☐ My insurance company incorrectly processed my claim
- ☐ My prescription drug was denied
- ☐ My prior authorization for a procedure or service was denied
- ☐ My provider was out-of-network
- ☐ My coverage was terminated
- ☐ I am being billed for a preventive service
- ☐ My complaint is related to the No Surprises Act
- ☐ I am being balance billed by my provider
- ☐ My complaint is about the quality of care I've received from my provider
- ☐ Something else

8. Indicate if MDH can share your complaint with your HMO. Please note that if we cannot send your complaint to your HMO, it may limit the steps we can take to investigate your complaint.

Acknowledgement and sign-off (Complaint)

As part of your complaint, MDH may find it helpful to send a copy of your complaint to your HMO. Unless you tell us not to, a copy of your complaint may be sent to your HMO.

- ☐ Do not send a copy of my complaint to my HMO. I understand this may negatively impact MDH's ability to get relevant information from my HMO.

9. Sign your complaint.
- Please read the information carefully before signing. By typing your name in the signature field, you are electronically signing this form; your electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Statutes, Chapter 325L.07)
 - The date will fill in automatically

Signature (required)

Date

Your Full Name

10/21/2025

- If you are filing a complaint for someone else, you will also need to enter your relationship to the patient.

Signature (required)

Date

Your Full Name

10/21/2025

Relationship to Patient (required)

Relationship

10. Click "Submit Complaint"

Submit Complaint