Provider Complaint Form

Request Date:_____

Provider Information

Name: _____

Address:_____

City: _____

Telephone:_____

Fax: _____

Contact Person:_____

Patient Information ❍ **Multiple Members (list separately)**

Name: _____

ID #:_____

Date of Birth:_____

Service Provided Information

Date(s) of Service: _____

Place of Service: _____

√ Complaint Reason

__ WellCare Administration
__ Member Behavior
__ Health Care Delivery
__ Provider Reimbursement
__ Contracting

Explanation of Issue(s):

_____
_____
_____
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Fill out the form completely and keep a copy for your records. Send this form with all documentation to support the complaint to WellCare. Attn: ***Customer Service*** at P.O. Box 31370, Tampa, FL 33631-3370. Your request will be processed once all necessary documentation is received and you will be notified of the outcome.

Failure to submit supporting documentation may delay our response to your complaint.