# Provider Complaint Request 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):**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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 31384 Tampa, FL 33631-3384 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**.