



Provider Complaint Form

Request Date: _____

Complaint(s) Regarding Multiple Patients?

Yes No

Provider Information

Name: _____

Address: _____

City: _____

Telephone: _____

Fax: _____

Contact Person: _____

Patient Information

Name: _____

ID #: _____

Date of Birth: _____

Service Provided Information

Date(s) of Service: _____

Place of Service: _____

Reason for Complaint

- 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. Please note that information regarding multiple patients can be submitted together in one request. Send form(s) with all documentation to support the complaint(s) 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.