



The Provider Relations Department of WellCare of Georgia, Inc. is committed to providing the most up-to-date and accurate information available, so that you can run your practice efficiently. To that end, please take a moment to complete this survey and tell us how we are doing. This will help us better serve you in the future.

**Today's Date:** \_\_\_\_\_

**Provider Name:** \_\_\_\_\_

**Name of Representative:** \_\_\_\_\_

- 1. Was the Provider Relations Representative courteous and professional?  Yes  No
- 2. Overall, are you satisfied with the service you have received today from your Provider Relations Representative?  Yes  No
- 3. Was the Provider Relations Representative able to answer your questions?  Yes  No  
If no, please explain.

\_\_\_\_\_  
\_\_\_\_\_

4. What did you find most helpful about today's meeting?  
\_\_\_\_\_  
\_\_\_\_\_

5. Please mark your specific areas of concern or items that may require additional consideration below: (please check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> HEDIS           | <input type="checkbox"/> Claim Resolution             |
| <input type="checkbox"/> Web Education   | <input type="checkbox"/> EDI                          |
| <input type="checkbox"/> EFT             | <input type="checkbox"/> Provider Setup/Credentialing |
| <input type="checkbox"/> Auth Resolution | <input type="checkbox"/> Other (explain below)        |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

You may return this survey to your Provider Relations Representative or fax it confidentially to **813-464-8287**.