HealthEase Staywell WellCare

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

__ Plan Administration
__ 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: Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384

You may also fax this completed form to **(866) 388-1769**

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.