

Provider Complaint Form

Request Date: _____

Provider Information

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

Name: _____

Name: _____

Address: _____

ID #: _____

City: _____

Date of Birth: _____

Telephone: _____

Service Provided Information

Fax: _____

Date(s) of Service: _____

Contact Person: _____

Place of Service: _____

√ Complaint Reason

Plan Administration
 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: 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.