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

__ WellCare Administration
__ Member Behavior
__ 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: ***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.