



IMHS Provider Complaint Form

Please complete and mail or fax to:
504 Lavaca, Suite 850 • Austin, Texas • 78701 • Phone: 512-406-7200 • Fax: 1-866-704-3063

Provider Complaint Form

Please print clearly and legibly

Provider Name: _____
Respond to attention of: _____
Form completed by (check one): Provider Provider Office Staff
Phone number: _____
Street address: _____
City: _____ State: _____ Zip: _____ County: _____
Email address: _____ Fax number: _____
Are you a contracted provider: (check one): Yes No
NPI#: _____ Tax ID#: _____
Provider ID#: _____

Complaint type (check one):

Claims Processing Provider Contracts
 Pre-authorization/ Pre-certification Utilization Review (UR)/ Utilization Management (UM) Other
If "other" please specify: _____

Complaint Details

Please describe complaint? Please include date of incident, dates of service, to assist us in the investigation and resolution of your complaint.

How can IMHS fairly resolve your issue?

Member Info (if applicable)

If concerning multiple members, please fax information to: 1-866-704-3063; Attn: Quality Improvement

Member's Name: _____ Member's Medicaid ID: _____
Claim# (if applicable): _____ Date(s) of Service: _____

For Administrative Use Only:

Complaint No.: _____ Date Received: _____