

# Provider Complaint Form



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 Cenpatico fairly resolve your issue?

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

### Member Info (if applicable)

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

Member's Name: \_\_\_\_\_ Member's Medicaid ID: \_\_\_\_\_

Claim# (if applicable): \_\_\_\_\_ Date(s) of Service: \_\_\_\_\_

*Please complete and mail or fax to:*

**504 Lavaca, Suite 850 • Austin, Texas • 78701 • Phone: 512-406-7200 • Fax: 866-704-3063**

*For Administrative Use Only:*

Complaint No.: \_\_\_\_\_ Date Received: \_\_\_\_\_

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