

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/ Utilization Review (UR)/ Utilization
Pre-certification 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: _____