

Provider Complaint Form



Provider Name: _____

Respond to attention of: _____

Form completed by (check one): Provider Provider Office Staff (name)

Phone number: _____

Street address: _____

City: _____ State: _____ Zip: _____ County: _____

Email address: _____ Fax number: _____

Cenpatico contracted provider? Yes No

NPI#: _____ Tax ID#: _____

Provider ID#: _____

Complaint type (check one):

Claims Processing

Contracts

Service

Authorization

Utilization Management

Other

If "other" please specify: _____

Complaint Details

Please summarize your complaint. Include relevant dates of service, actions and communications with Cenpatico staff to assist us in the investigation and resolution of your complaint.

Resolution requested:

Member Information (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: _____