ABSOLUTE TOTAL CARE TOTAL Healthy Connections

Cenpatico Improving Lives

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:

12515-8 Research Blvd., Suite 400 · Austin, TX ·78759 · Phone: 512-406-7200 · Fax: 866-704-3063

For Administrative Use Only:

Complaint No.: _____ *Date Received:* _____