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:* _____