

# 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.

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Resolution requested:

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## Member Information (if applicable)

*If concerning multiple members, please mail information; Attn: Quality Improvement*

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

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

*Please complete and mail to:*

**PO Box 92050 • Elk Grove Village, IL • 60009**

**Phone: 866-329-4701**

*For Administrative Use Only:*

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