Provider Complaint Form

Request Date: _____
Complaint(s) Regarding Multiple Patients? O Yes O No

Provider Information

Name: _____

Address: _____

City: _____

Telephone: _____

Fax: _____

Contact Person: _____

Patient Information

Name: _____

ID Number: _____

Date of Birth: _____

Information on Service Provided

Date(s) of Service: _____

Place of Service: _____

√ Reason for Complaint

__ WellCare Administration
__ Member Behavior
__ Health Care Delivery
__ Provider Reimbursement Process
__ Contracting

Explanation of Issue(s)

Fill out the form completely and keep a copy for your records. Please note that information regarding multiple patients can be submitted together in one request. Send form(s) with all documentation to support the complaint(s) to Heritage Health Plans Inc. Attn: ***Grievance Department,* P.O. Box 31384 Tampa, FL 33631-3384**. Your request will be processed once all necessary documentation is received and you will be notified of the outcome.

***Failure to submit supporting documentation may delay our response to your complaint.**