Please return this form to Network Development via email at networkrelations@wellhealthqc.com or fax at (702) 522-1357.

Provider / Group Complaint Form

Group Information

Group DBA _____ TIN _____

Individual Placing Complaint _____

Phone Number _____ Email _____

Complaint Information

Please indicate the area(s) of your complaint.

☐ Authorizations	☐ PCMH
☐ Eligibility (Member Services)	☐ Specific Member(s)
☐ Claims	☐ Other Provider / Group (In Network)
☐ Provider Relations	☐ Other

Please complete the applicable sections below with details regarding your complaint.

A. AUTHORIZATIONS

☐ Staff is difficult to reach ☐ Appeal of denial ☐ Timeliness of Auth Processing

Please provide a complete and detailed explanation of your case and issue. Attach additional pages as needed.

_____

_____

_____

Details of Auth Request

_____ _____

Provider Requesting Provider Group

_____

Procedure / Medication Requiring Auth

_____ Method of Submission: ☐ Email ☐ Fax ☐ Physical

Date Request was Submitted

_____ _____

Email / Fax / Individual Submitted To / At Potential Date of Procedure

B. ELIGIBILITY / MEMBER SERVICES

☐ Timeliness of Response / Hold Times ☐ Quoted Incorrect Benefit Information

Please provide a complete and detailed explanation of your case and issue. Attach additional pages as needed.

C. CLAIMS

☐ Incorrect Payment ☐ Denied Claim ☐ Other

Please provide a complete and detailed explanation of your case and issue. Attach EOP(s) in question with supporting documentation as needed.

D. PROVIDER / NETWORK RELATIONS

☐ Timeliness of Response / Lack of Response ☐ Inaccurate Data / Confusing Information

☐ Fee Schedule Issue / Inquiry ☐ Contracting Issue / Inquiry

Please provide a complete and detailed explanation of your case and issue. Attach additional pages as needed.

E. OTHER PROVIDER / GROUP SPECIFIC (IN-NETWORK)

☐ Complaint against another Provider ☐ Complaint against a Group/Entity

☐ Unresponsive (Referrals, etc.) ☐ Rude / Inappropriate Staff

Provider / Group Details

Group Name

Provider / Staff Name

Please provide a complete and detailed explanation of your case and issue. Attach additional pages as needed.

F. SPECIFIC MEMBER(S)

☐ Complaint against a member(s) and/or participant family. ☐ Other

☐ Service Refusal for specific member(s) and/or participant family.

Member Details

Member Name

Dependent Name (if applicable)

Member ID Number

Member Payor Group (Insurance)

Date of Service / Incident (if applicable)

Name of Staff Member(s) Involved (if applicable)

Please provide a complete and detailed explanation of your case and issue. Attach additional pages as needed.

G. PATIENT CENTERED MEDICAL HOME (PCMH)

☐ Incorrect Payment ☐ Contracting Issue / Inquiry ☐ Non-Qualifying Physician

Please provide a complete and detailed explanation of your case and issue. Attach additional pages as needed.

H. OTHER

Please provide a complete and detailed explanation of your case and issue. Attach additional pages as needed.