WELLHEALTH Quality Care
A MedSource Health Care Company

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.

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Details of Auth Request

______________________ ______________________
Provider Requesting Provider Group

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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.

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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.

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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.

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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.

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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.