

Provider Complaint Form

Request Date:	
Provider Information	Patient Information Multiple Members (List separately
Name:	Name:
Address:	ID#:
City:	Date of Birth:
Telephone:	Service Provided Information
Fax:	Date(s) of Service:
Contact Person:	Place of Service:
Complaint Reason	
_ WellCare Administration _ Member Behavior _ HealthCare Delivery	_ Provider Reimbursement _ Contracting
Explanation of issue(s):	

Fill out the form completely and keep a copy for your records. Send this form with all documentation to support the complaint to WellCare. Wellcare Attn: Complaints Dept., 7700 Forsyth Blvd St Louis, MO 63105. 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.