SENDERO HEALTH PLANS

PROVIDER COMPLAINT FORM

Please fill out the form as completely as possible
Mail the completed form to:

Sendero Health Plans
Attn: Network Management
2028 East Ben White Rd., Suite 400
Austin, TX 78741

The outside of the envelope should be marked "Confidential."

PROVIDER NAME AS NOTED IN PROVIDER DIRECTORY:	**PROVIDER TAX ID:**
PROVIDER ADDRESS:	
PROVIDER TYPE ☐ Ancillary ☐ Hospital ☐ PCP ☐ Specialty ☐ Other: _____	
DESCRIPTION OF COMPLAINT: *Please be specific*	
Attaching additional information? Yes No	
EXPECTED OUTCOME:	
Contact Name (please print)	Title Date ( ) Phone Number
Signature	E-Mail Address ( ) Fax Number