SENDERO HEALTH PLANS

PROVIDER COMPLAINT FORM

Please fill out the form as completely as possible

MAIL: Sendero Health Plans
Attn: Network Management
2028 East Ben White, Suite 400, Austin TX 78741
FAX: 512-901-9704 / **PHONE**: 1-844-800-4693 / **EMAIL**: providers@senderohealth.com

If you disagree with a Sendero claim determination, you must complete the Claim Reconsideration/Appeal Request Form. Claim reconsideration and appeal requests submitted on the Provider Complaint Form will be rejected.

PROVIDER NAME AS NOTED IN PROVIDER DIRECTORY:	**PROVIDER TAX ID:**

PROVIDER TYPE
Please circle one

Ancillary Hospital PCP Specialty

Other: _____

DESCRIPTION OF COMPLAINT:
Please be specific

Attaching additional information? Yes No

EXPECTED OUTCOME:

Contact Name (print)	Title Date	( ) Phone Number
Signature	E-Mail Address	( ) Fax Number