

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**: Senderoproviders@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 Other:	Hospital	PCP S	Specialty
DESCRIPTION OF COMF Please be specific	PLAINT:			
	nation? Yes No			
Attaching additional information? Yes No EXPECTED OUTCOME:				
Contact Name (print)		Title	Date	() Phone Number
Signature		E-Mail Address		() Fax Number