

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:** 1-855-526-7388

ONLINE: providers@senderohealth.com The communication should be marked Confidential.					
PROVIDER NAME AS NOTED IN PROVIDER DIRECTORY:			PROVIDER TAX ID:		
PROVIDER ADDRES	SS:				
PROVIDER TYPE		☐ Hospital	☐ PCP	☐ Specialty	
DESCRIPTION OF C	OMPLAINT:				
Attaching additional ii	nformation? Yes	No			
EXPECTED OUTCOM	VIE.				
Contact Name (pleas	e print)	Title	Date	() Phone Number	
Signature		E-Mail Address		() Fax Number	