Provider Complaint Form
To submit a complaint, please complete the fields below and mail or fax this form to:

PA Health & Wellness
Complaints & Grievances
300 Corporate Center Dr. Suite 600
Camp Hill, PA 17011
Fax: 1-866-683-5369
Email: PHWComplaintsandGrievances@PAHealthWellness.com

Physician / Provider Name: ________________________________________________

Name of individual completing this form: _____________________________________

Title of individual completing this form: ______________________________________

Form completed by (check one): ☐ Provider ☐ Provider Office Staff

Phone number: __________________________

Street address: __________________________

City: ___________________ State: ___________ Zip: ___________ County: ___________

E-mail address: __________________________ Fax number: ________________________

Are you a contracted provider? (check one): ☐ Yes ☐ No

NPI Number: __________________________ Tax ID Number: _______________________

Complaint type (circle one):
Attitude and Service Health Plan Decision to Terminate Provider's Contract with PHW
Marketing Complaint Process
Plan Administration – Misc. Physician/Provider Contracts
UR/UM – Non Covered Benefit UR/UM – Case Management
UR/UM – Late Notification Other UR/UM – Prior Authorization
PHW’s Policies or Procedures UR/UM – Misc.
Credentialing Decision Other
Decision to Sanction a Provider

If "other" please specify: ______________________________________________________

Complaint Details
Please describe complaint:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

How can PA Health & Wellness fairly resolve your issue?
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Member Info
(Required if your complaint is about a specific member.)

Participant Name: __________________________ Participant ID #: __________________

Participant DOB: ___________ Date(s) of Service: ____________________________