

## Provider Formal Administrative Complaint Form

### Purpose

A provider has the right to file an administrative complaint for issues involving Iowa Total Care policies, procedures or administrative functions. Complete this form for formal complaints regarding administrative issues.

Administrative complaints do not include claim disputes, member grievances or appeals about a service that has been denied, reduced or suspended. For information on how to file a claim dispute, assist a member with a grievance or an appeal, please consult our Provider Manual.

### Timeframes

A provider may file an administrative complaint at any time. Iowa Total Care will send a written response to the provider for the complaint within 30 calendar days. If the complaint cannot be resolved within 30 calendar days, the provider relations team will request a 14 calendar day extension from the provider in writing. If the provider requests the extension, it will be approved by Iowa Total Care.

### How to Submit

Complete the requested information and submit the form through one of the following methods:

- **In person**
- **Provider Services Phone:**  
1-833-404-1061 (TTY: 711)
- **Email:**  
[ProviderRelations@IowaTotalCare.com](mailto:ProviderRelations@IowaTotalCare.com)
- **Fax:** 1-833-208-1397

- **Mail:**  
Iowa Total Care  
Attn: Complaints  
1080 Jordan Creek Parkway  
Suite 400 South  
West Des Moines, IA 50266

### Provider Information

Date: \_\_\_\_\_ TIN: \_\_\_\_\_ NPI: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### External Submitter Information

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Provider Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Formal Complaint Details

Please provide details pertaining to the formal complaint. Please attach any supporting documents or examples as needed.

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#### Internal Use Only

Iowa Total Care team members must complete this section when submitting the form on the provider's behalf.

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Method of submission:

☐ Email

☐ Fax

☐ In Person

☐ Phone

☐ Mail

Complete the mandatory confirmation statement below when a provider submits a formal complaint in person, by email or by phone.

#### Mandatory Confirmation Statement

"Are you requesting a formal complaint be submitted on your behalf?"

Did the team member read or provide the mandatory confirmation statement to the provider? (if applicable)

☐ Yes

☐ No

☐ Not applicable