



NON-MEDICARE MEMBER FORMAL GRIEVANCE FORM

Please use this form or a separate letter for information needed for the review of your grievance. Be as complete and detailed as possible. If the grievance is about a physician(s), be sure to list the name(s) of the doctor(s). If medication is the issue, list all the names of the medications. If the grievance is about a balance billing, please attach the billing statement from the provider.

Member Name: _____ Member Phone: _____

Member ID#: _____

Relationship to Member: Self Appointed Representative Power of Attorney Parent/Guardian

Type of Coverage: Medicaid PeachCare for Kids

Type of Grievance

- | | |
|---------------------------------------|--|
| _____ Physician Related | _____ Enrollment/Disenrollment Related |
| _____ Hospital Related | _____ Provider- Poor Customer Service |
| _____ Delay in Getting Physician Care | _____ Telephone Problems |
| _____ Delay in Getting Hospital Care | _____ Transfer of Centers |
| _____ Plan-Poor Customer Service | _____ Other: _____ |

Date of occurrence that caused grievance: _____
(month, day, year)

Nature of Complaint:

I would like my grievance to be handled as: Expedited/Urgent: 72 hours Standard: 45 calendar days

If you feel should be handled as Expedited, explain why:

How would you like your grievance resolved?

What date(s) was the service provided? _____

Name of physician or hospital who provided the service: _____

Have you discussed this grievance with any company staff/personnel? Yes No

If yes, with whom?

1. _____
2. _____
3. _____

What did they say?

1. _____
2. _____
3. _____

If your grievance involves balance billing, have you paid the bill you are referencing? Yes No

Where did you receive the service? _____

When? _____ By whom? _____

Other comments:

I HEREBY request a review of the Grievance described in this document and understand that in order for the Grievance to be reviewed, WellCare of Georgia, Inc., (the Health Plan), may need medical records and other records or other information related to my grievance. I authorize persons or entities that have any medical or other records, or knowledge of me or my dependants, to release such information to WellCare of Georgia, Inc., (the Health Plan). Those persons or entities may include any: 1) licensed physician; 2) medical practitioner; 3) hospital, 4) clinic or other medical or medically-related provider; 5) insurer; 6) employer; or 7) other organization, institution, or person. I specifically authorize the release of the following records or information if need for the review of my Grievance: any and all medical records and information about, associated with, or with reference to: 1) a positive test result for HIV infection; 2) ARC; 3) AIDS; 4) alcohol or drug dependency; and 5) mental and nervous disorders.

I also understand that if the Grievance described in this form is not resolved to my satisfaction, I may request a Second-Level review to the Corporate Appeals and Grievance Committee.

Member Name (please print)

Date

Member's or Representative's Signature

Please fax this form to (866) 388-1769, or mail to:

WellCare Health Plans, Inc.
Attn: Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384