



WellCare of Ohio, Inc.

NON-MEDICARE MEMBER FORMAL GRIEVANCE FORM

Please use the 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 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 GRIEVANCE:

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

Date of Occurrence that caused Grievance: ____/____/____

Explain Issue: _____

I would like my grievance be handled as: Expedited/Urgent: 2-business days (Grievance about Medicaid covered services)
 30-calendar days (Grievance about non-claim related issue)
 60-calendar days (Grievance about claim related issue)

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 your are referencing? Yes No

Where did you receive the service? _____

When? _____ By whom? _____

Have you contacted the provider? ___ Yes ___ No

If so, what did they say? _____

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 Ohio, 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 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) AIDS; 3) alcohol or drug dependency; and 4) 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 Grievance Committee.

Print Member Name

Date

Member or Authorized Representative's Signature

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

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