WellCare Health Plans

• WellCare HMO, Inc • HealthEase of Florida, Inc. • WellCare of New York, Inc.

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: ❍ Healthy Kids ❍ Staywell ❍ HealthEase ❍ Commercial

Type of Grievance

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

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

Nature of Complaint:

____

____

____

I would like my grievance to be handled as: ❍ expedited ❍ 72 hours ❍ Standard: 30 calendar days

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

____

____

____

____

How would you like your grievance resolved?

____

____

____

____

WellCare Health Plans

• WellCare HMO, Inc • HealthEase of Florida, Inc. • WellCare of New York, Inc.

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, 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 (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
Attn: Grievances
P.O. Box 31384
Tampa, FL 33631-3384