



Filing a Grievance for WellCare Medicaid Members in Georgia

NOTE: If a member files a grievance against a provider, WellCare will fax and mail a request to the provider for response. The provider has 10 business days to respond and submit medical records for review. If the provider does not respond, a second fax and letter are sent, giving the provider an additional five days to respond. Failure to respond may result in the provider's panel being closed to new patients.

Please see the WellCare Provider Handbook for additional information.

Visit our Web site at
georgia.wellcare.com
for regular updates.

1-866-231-1821

Monday–Friday, 7am–7pm Eastern
georgia.wellcare.com

The grievance process is for members to address concerns such as quality of care, wait times, provider office environment issues or obtaining appropriate information. A member or member's representative may file a grievance.

Three Ways to File a Grievance:

1. MAIL written grievance and documentation to:

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

2. FAX written grievance and documentation to: 1-866-388-1769

3. TELEPHONE the Provider Hotline at: 1-866-231-1821

Process for Filing a Grievance:

Expedited Request

The member is notified immediately by telephone if the grievance is expedited. If the request for expedited determination is denied, the grievance is handled using the standard process.

OR

Standard Request

WellCare will acknowledge receipt of the request within 10 business days.

After the grievance is investigated, a determination will be made and a closure letter sent to the member.

FOR EXPEDITED REQUESTS: WellCare will resolve the grievance within 72 hours.

FOR STANDARD REQUESTS: WellCare will resolve the grievance within 90 calendar days.

If the member is not satisfied with the decision, the member has the right to request a second-level grievance within 30 calendar days of the date on the determination letter.

