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 ______ 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  ○ 72 hours  ○ Standard: 30 calendar days

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

How would you like your grievance resolved?
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
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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