WellCare | Healthy Connections

## SOUTH CAROLINA 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 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:

_____

_____

_____

_____

_____

How would you like your grievance resolved? _____

What date(s) was the service provided? _____

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 South Carolina, 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 dependents, to release such information to WellCare of South Carolina, 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 needed 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.

_____ _____

Member Name (please print) Date

_____

Member's or Representative's Signature

Please fax this form to **1-866-388-1769**, or mail to:

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