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  ______ 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:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

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