Formal Grievance Form for WellCare of New Jersey Health Plan Members

Please use this form for information needed for the review of your grievance. Be as complete and detailed as possible. If the grievance is about a provider(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 bill you received from a provider or providers, please attach the billing statement from the provider. If you need to include more information, you can attach additional pages.

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
______ WellCare – 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 (explain what happened):

How would you like your grievance resolved? ____

What date(s) was the service provided? ____

Have you discussed this grievance with WellCare? Yes ⬭ No ⬭

If yes, with whom?

1. ____
2. ____
3. ____

What did they say?

1. ____
2. ____
3. ____

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If your grievance involves a bill, have you paid the bill you are referencing?
◯Yes ◯No

Where did you receive the service?
____

When? ______________________________ From 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 New Jersey, 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 New Jersey, 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.

Release and disclosure are authorized only to the extent any of those persons or entities may deem appropriate for a purpose consistent with the review of a grievance regarding health care services. This authorization will expire one year from the date below. The expiration will apply to all information not previously released pursuant to this authorization. This authorization may be revoked or withdrawn at any time. A revocation or withdrawal will apply to all information not previously released pursuant to this authorization.

____ ___________________________
Member Name (please print) Date

____
Member's/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 31368
Tampa, FL 33631-3384

If you have questions, call Customer Service at <1-888-453-2534>. TTY users should call <1-877-247-6272>. We are open <Monday – Friday>, <8am to 6pm Eastern >

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This document is available in alternate languages. Please call Customer Service at the number listed above should you wish to receive this in an alternate language.

Este documento se encuentra disponible en idiomas alternativos. Por favor llame a Servicio al Cliente al número indicado anteriormente si desea recibir esto en un idioma alternativo.

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