Member Complaint Form

Complete and mail or fax to
Allwell from Buckeye Health Plan | Appeals & Grievances/Medicare Operations
7700 Forsyth Blvd. |St. Louis, MO 63105
Fax: 1-844-273-2671

Allwell from Buckeye Health Plan will have a resolution to your complaint no later than 30 days of the date you submit your complaint. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. However, if we take this extension, we will notify you or your representative. We can usually help you right away or at the most within a few days. If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal", we will automatically give you a "fast" complaint. If you have a "fast" complaint, it means we will give you an answer within 24 hours.

If you need any help, please call us at 1-855-766-1851 for HMO and at 1-866-389-7690 for HMO SNP (TTY: 711). From October 1 through March 31, our office hours are 8:00 a.m. to 8:00 p.m. 7 days a week. From April 1 through September 30, our office hours are 8:00 a.m. to 8:00 p.m. Monday through Friday. Additionally, from April 1 through September 30, calls on evenings, weekends and Federal holidays will be handled by our automated phone system. You can also visit https://allwell.buckeyehealthplan.com/.

Member's Name (First and Last): _____

Medicare ID Number: _____ Member Date of Birth: _____

Relationship to Member *(please choose one): ☐ Self ☐ Parent ☐ Legal Guardian ☐ Spouse

☐ Other: _____

**If other than "Self" is selected, proof of guardianship, power of attorney or an Appointment of Representative (AOR) form will be required. The AOR form can be found on our website.*

Phone Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Provider: _____

Complaint Type (please choose one):

☐ Access

☐ Service Request

☐ Claims Payment Issue

☐ Appeals

☐ Benefits

☐ Prescription Drug Request or Issue/Coverage Determination & Redetermination Process

☐ Customer Service

☐ Enrollment & Disenrollment

☐ Fraud & Abuse

☐ Marketing

☐ Privacy Issues

☐ Quality of Care

Is this complaint about your medications? (please choose one): ☐ Yes ☐ No

If you answered YES above, do you have enough supply for the next 7 days? (please choose one):

☐ Yes ☐ No

What is your complaint?

_____
_____
_____
_____
_____
_____
_____
_____

How can Allwell from Buckeye Health Plan resolve your issue?

_____
_____
_____
_____
_____
_____

What is the best way to reach you regarding this complaint? (please choose one): ☐ Phone ☐ Email
☐ Other _____

Please provide further contact information (i.e. phone number, email address, etc).

_____

For Administrative Use Only

Complaint Number: _____ *Date Received:* _____