Grievance Form

Mail to: Magellan Complete Care
Attn: Grievance and Appeals Department
PO Box 691029
Orlando, FL 32769

Member name: | Member ID:

Address:

Cell phone number: | Home telephone number:

Date problem occurred:

Where did this happen:

Did you call anyone at Magellan or the doctor's office for help? ○ Yes ○ No
If yes, what is their name and telephone number?

Name: | Telephone number:

Please describe the problem that you experienced:

Did you ask anyone to resolve the problem you encountered? ○ Yes ○ No

What is the best time to speak with you? ○ 8:30 am – 12:30 pm ○ 1:00 pm – 5:00 pm

I understand that Magellan Complete Care will (1) contact me within 5-working days of receipt of this form; (2) I will be notified by Magellan Complete Care regarding their initial findings; (3) I will be notified of my Rights to an appeal if I'm not satisfied with Magellan Complete Care's findings.

Signature of Member/Representative/Legal Guardian *Date*

Print Name of Member/Representative/Legal Guardian

Contact telephone number: | Relationship if not member:

Need assistance? Please call 1-800-327-8613 (TTY 711)