

## Member Complaint Form

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

Allwell from MHS Health Wisconsin 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 1-833-981-0042 for HMO and at 1-877-935-8024 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.mhswi.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?

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How can Allwell from MHS Health Wisconsin resolve your issue?

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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).

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***For Administrative Use Only***

*Complaint Number:* \_\_\_\_\_ *Date Received:* \_\_\_\_\_