Member Complaint Request Form

Magellan Healthcare, Inc. (Magellan) members, their authorized representatives, or other trusted person have the right to file a complaint. You will not be penalized for filing a complaint.

If the complaint is about Youth Empowerment Services (YES) and you wish to file anonymously, you may file a complaint with the Idaho Department of Health and Welfare (IDHW) at:

- **Phone:** 1-208-364-1910
- **Email:** yes@dhw.idaho.gov
- **Online:** Youth Empowerment Services Concerns and Complaints form

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How to request a complaint with Magellan:

1. Fill out and sign the form below. You may want to keep a copy for your records.
2. You can include, with this form, any additional documentation to support the complaint.
3. Fax, email, or mail your complaint to:
   - **Email**: IDAC@magellanhealth.com
   - **Mail**: Magellan Quality Improvement Dept.
   - **Fax**: 1-888-656-9795
4. A complaint can also be submitted verbally by calling Magellan at 1-855-202-0973 (TTY 711).
5. If additional information is needed, you might be contacted by a Magellan representative.
6. You will receive a written letter confirming receipt of your complaint within 5 business days.
7. Depending on the type of complaint this is categorized as, you could receive a resolution letter within 10 business days of Magellan's acceptance of your complaint form.
8. Some complaints could take up to 30 days to receive a written closure letter depending on if the complaint was related to the quality of care you received.
9. If you would like to have someone represent you during your complaint, please fill out the second form and include it with your submission.

Information about the complainant (You)		Your (Member's) Name	Your (Member's) Email Address	
Phone Number	Can we leave you a voicemail? Select Y or N	Date of Birth	Member ID#	
Street Address		City	State	Zip Code

*Your ID number can be found on your IBHP issued benefits card.

Information about your complaint

Reason for your complaint

Information about the Provider

(ONLY if complaint is about a Provider)

Provider's Phone Number	Provider's First Name	Provider's Last Name	
Provider's Street Address	City	State	Zip Code

Authorized Representative Information

You can ask someone to assist you with your complaint. If you decide to do this, please let us know below and fill out the Authorized For Use and Disclosure Form, then send it back to us with this complaint form. This way, we can share the complaint information with that person as we do with you, unless you ask us to stop.

Authorized Representative Name & Relationship to you	Phone Number		E-mail Address
Street Address	City	State	Zip Code
Signature of You (Member), Legal Guardian/Parent if a minor or authorized representative and print name			Date

Mail, Email, or Fax this Complaint Form, any supporting documents, and the signed Authorized Use and Disclosure Form (If needed) to:	**Please call our Customer Experience Associates if you have questions or need help with completing this complaint form.**
▪ **Mail:** Magellan Healthcare, Inc., Attn: Idaho Quality Department, P.O. Box 2188, Maryland Heights, MO 63043 ▪ **Email:** IDAC@magellanhealth.com ▪ **Fax:** 1-888-656-9795	▪ **Phone:** 1-855-202-0973 ▪ TTY: 711