Provider Payment Dispute Request Form

Send this form with all pertinent medical documentation to support the request to WellCare Health Plans, Inc. **Attn: Appeals Department** at P.O. Box 31368 Tampa, FL 33631-3368. You may also fax the request if less than 10 pages to (866) 201-0657. Your appeal will be processed once all necessary documentation is received and you will be notified of the outcome.

☐ Child Health Plus
☐ WellCare Medicare
☐ Family Health Plus
☐ HealthEase Medicaid
☐ HealthEase Healthy Kids
☐ Staywell Healthy Kids

Request Date: _____
Has the service been provided yet? __Yes __ No
Expedited Request? __ Yes __No
(See reverse side for definition of Expedited Request)

Provider/Appellant Information

Name _____
Address: _____
City: _____
_____
Telephone: _____
Fax: _____
Contact Person: _____

Patient Information

Name: _____
ID Number: _____
Date of Birth:

Service Provided Information

Date(s) of Service: _____
Place of Service: _____

√ **Reason Given for Denial (from EOB or Denial letter)**

__ Medical Necessity
__ Lack of Information
__ Not Prior Authorized
__ Benefits Exhausted
__ Out of Network
__ Not a Covered Benefit
__ Untimely Filing
__ Invalid Code
__ Inclusive
__ Exclusive
__ Incidental to
__ Medicare Payment in Full
__ Claim Not Billed as Authorized
__ Exceeds Authorization
__ Other_____

Reason for Request:

_____
_____
_____
_____
_____
_____
_____

Unless your contract allows otherwise WellCare will pay the Medicare or Medicaid allowable, depending on member's plan, for the service performed if we overturn our previous decision. By signing this form you agree to these terms and will not bill the member, except for applicable co-pays.

Signature: _____ Date: _____

This form is to be used when you want to appeal a claim or authorization denial. Fill out the form completely and keep a copy for your records.
***See other side for additional information**

Provider Payment
Dispute Request Form

Filing on Member's Behalf
Member appeals for medical necessity, out-of-network services, or benefit denials, or services for which the member can be held financially liable for services must be accompanied by an Appointment of Representation form or other office documentation signed and dated by the member you are appealing on behalf of, unless you are an attorney, power of attorney, court appointed guardian or health care proxy agent with associated documentation.

Expedited Request
Applies when the standard timeframe could jeopardize the life or health of the member, or the member's ability to regain maximum function.

Documentation needed: All Medical Information Needed to Determine Medical Necessity
Examples:

- **Inpatient or Observation stays -** Doctor orders, progress notes, ER notes, medication record, lab reports, nurses notes, consultation reports, PT/OT/ST notes (if applicable)
- **Procedures -** procedure report, supporting consultation reports, PCP progress notes, Referring MD script
- **Consultations**- consultation report, Referring MD script
- **PT, OT, ST -** progress notes, evaluations, summaries, Referring MD script
- **Radiology -** reports, Referring MD script
- **Timely filing -** billing notes, fax confirmation, certified mail card signed