WellCare | Healthy Connections

SOUTH CAROLINA MEMBER FORMAL APPEAL FORM

Please use this form or a separate letter to request a formal appeal. Be as complete and detailed as possible.

Member Information

Date: _____

Member Name: _____

Member ID#: _____

Member Phone: _____

Service Provided Information

Service Requested/Performed: _____

Date(s) of Service: _____

Rendering Provider: _____

Relationship to Member: ☐ Self ☐ Appointed Representative ☐ Power of Attorney ☐ Parent/Guardian

Reason Given for Denial:

☐ Medical Necessity ☐ Lack of Information ☐ No Prior Authorization ☐ Benefits Exhausted
☐ Out of Network ☐ Not a Covered Benefit ☐ Claim Not Billed as Authorized ☐ Exceeds Authorization
☐ Other

I would like my appeal to be handled as: ☐ Expedited/Urgent: 72 Hours
☐ Standard: 30 Calendar Days

If you feel your request should be handled as Expedited/Urgent, please explain why:

_____
_____
_____
_____
_____
_____

Please explain the reason for your appeal:

_____
_____
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_____

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