Provider Administrative Review Request Form

Request Date: _____

Providers may file appeals or disputes based on claim outcome within 120 days from date of remittance advice or EOP. Fill out the form completely and keep a copy for your records. Your appeal or dispute will be processed once all necessary documentation is received. Please allow 30 days for a response. If **all** necessary documentation is not received, a response may surpass the 30 day timeframe.

- ○ **Skilled Nursing Facility**
- ○ **Hospital**
- ○ **Home and Community Based Providers (Foster Home, Home Care, etc…)**
- ○ **Physician/Allied Health Practitioners**
- ○ **Other Health Care Providers (Lab, DME, etc…)**

Provider/Appellant Information

Name: _____ Provider # _____ Tax ID # _____

Telephone: _____ Fax: _____ Contact Person: _____

Patient Information

Name: _____ Member #: _____ Date of Birth: _____

Service Provided Information

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

Claim(s) Number: _____ Authorization Number: _____

Reason Given for Denial or Underpayment (from EOP or denial letter)

Clinical Appeals Only:	**Claims Disputes Only:**	**Claims Coding Disputes Only:**
☐ Medical Necessity	☐ Inclusive/Exclusive	☐ Claim Denial begins with "IH"
☐ Lack of Information	☐ Exclusive	☐ Claim Denial begins with "MK"
☐ No Prior Authorization	☐Incidental Procedures	☐ Claim Denial begins with "PD"
☐ Benefits Exhausted	☐ Bundling / Unbundling	
☐ Out of Network	☐ Time Limit for filing expired	
☐ Not a Covered Benefit	☐ Unlisted Procedure Codes	
☐ Exceeds Authorization	☐ Non-covered Code (NOFEE)	
☐ Other: _____	☐ EOB Required from Primary Payer	
☐ Retro Eligibility	☐ Other _____	
☐ Post Service Review	☐ Invalid COB payment received	
	☐ Claim Payment Underpaid	

Providers may seek an appeal within 120 calendar days of claims denial. Send this form with **all** pertinent medical documentation to support the request to WellCare Health Plans, Inc., Attn: **Appeals Department**, P.O. Box 31368, Tampa, FL 33631-3368. You may also fax the request if fewer than 10 pages to (866) 201-0657.	Claim payment disputes must be submitted in 120 days of the date of denial on the EOB. To initiate this process, please mail or fax this form and supporting documentation to 'Ohana Health Plan, **Claim Payment Disputes**, PO BOX 31370, Tampa, FL, 33631-3372. Fax (877) 277-1808	Inquiries related to **Explanation of Payment Codes and Comments** beginning with **IH**XXX, **MK**XXX, or **PD**XXX should be sent to: Payment Policy Disputes Department, PO BOX 31426, Tampa, FL 33631-3426.

Reason for Request:

_____
_____
_____
_____
_____
_____
_____
_____

By signing this form, you agree to these terms and will not bill the member, except for applicable co-pays.

Signature: _____ Date: _____

Clinical Appeals Only:
Filing on Member's Behalf
Member appeals for medical necessity, out-of-network services benefit denials or services for which the member can be held financially liable 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 30-calendar-day time frame could jeopardize the life or health of the member or the member's ability to regain maximum function. A decision will be made within 72 hours of receipt.

Required Attachments: 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, signed mail card
EOB Required from Primary Payor- explanation of payment or remittance advice from primary payor