Non-Participating Provider Claim Payment Dispute Form

Visit our Provider Portal **https://provider.wellcare.com/Provider/Login** to submit your request electronically. Send this form with all pertinent medical documentation to support the request to Wellcare Health Plans, Inc. **Attn: Claim Payment Disputes** at P.O. Box 31370 Tampa, FL 33631-3370. Your dispute will be processed once all necessary documentation is received and you will be notified of the outcome. Please fill in all provider and patient information fields below as they are **required to complete your request**.

Request Date: ______________________

Provider Information

Name: ______________________

Provider ID on Billed Claim: ______________________

NPI: ______________________

Tax ID Number: ______________________

Address: ______________________

City: ______________________

State: ____________ Zip Code: ____________

Telephone: ______________________

Fax: ______________________

Contact Person: ______________________

Patient Information

Name: ______________________

ID Number: ______________________

Date of Birth: ______________________

Service Provided Information:

Date(s) of Service: ______________________

Place of Service Code: ______________________

Claim #: ______________________

Authorization # (if applicable): ______________________

Denial Reason Code: ______________________

☑ Reason Given for Denial (from EOB or Denial letter)

- ☐ No Authorization on File or Obtained
- ☐ Lack of Information
- ☐ Out of Network
- ☐ Not a Covered Benefit
- ☐ Untimely Filing
- ☐ Invalid Code
- ☐ Inclusive
- ☐ Exclusive
- ☐ Underpayment Dispute
- ☐ Coordination of Benefits (COB) Dispute
- ☐ Claim Not Billed as Authorized
- ☐ Exceeds Authorization
- ☐ Other: ______________________
  (please identify code you are appealing)

If your denial is due to Clinical Criteria Not Met, Medical Service Not Approved, Authorization Denial for Medical Criteria Not Met, Benefits Exhausted, or Not a Covered Benefit, please use the Participating Provider Reconsideration Request Form. If authorization for services is not obtained prior to services being rendered, review may be subject to an uphold of our original decision.

(continued)

©2024 Wellcare. All Rights Reserved.

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: ____________________

This form is to be used when you have a payment dispute. Fill out the form completely and keep a copy for your records.