Participating Provider 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: Appeals Department** at P.O. Box 31368 Tampa, FL 33631-3368. 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)

- ☐ 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 _____

***If your denial is due to Medical Necessity, Prior Authorization, Authorization Denial, or Benefits Exhausted, please use the Participating Provider Reconsideration Request Form.**

continued on next page

Reason for Request:

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Unless your contract allows otherwise, Wellcare will pay the Medicare 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 have a payment dispute. Fill out the form completely and keep a copy for your records.