WellCare
Beyond Healthcare. A Better You.

Request for Redetermination of Medicare Prescription Drug Denial

Because WellCare Health Plans denied your request for coverage of (or payment for) a prescription drug, you have the right to an appeal. The means you may ask us to review our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for an appeal. To start the appeal, please fill out this form and send it to us by mail or fax:

Address:
WellCare Health Plans
P. O. Box 31383
Tampa, FL 33631

Fax Number:
1-866-388-1766

You may also ask us for an appeal through our website at www.wellcare.com.

Important Note: Expedited Decisions

☐ CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS
If you have a supporting statement from your doctor, please attach it to this request.

If you or your doctor believe(s) that waiting **7 days for a standard decision** could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. We will automatically make a decision **within 72 hours** if your doctor tells us that waiting 7 days could seriously harm your health. Without your doctor's support for an expedited appeal, we will decide whether your case requires a faster decision. **Please note that you cannot ask for a faster appeal if you are asking us to pay you back for a drug you already received.**

You can ask for a faster (expedited) appeal by calling 1-888-550-5252.

Who is making this request? Provider ☐ Member ☐ Appointed Representative ☐
***Appointed Representatives*:** Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

Complete the following ONLY if the person making this request is not the member or prescriber:

Requestor's Name		
Requestor's Relationship to Member		
Address		
City	State	ZIP Code
Requestor Phone		

Representation documentation for requests made by someone other than member or the member's prescriber:

Attach documentation showing the authority to represent the member (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.

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***REQUIRED FIELDS – ONE MEDICATION PER FORM.**

*Member Name:	
*Member ID #:	*Date of Birth:
*Member Phone:	*Duration (how long therapy lasts): **Indefinite?** ☐ **YES** ☐ **NO** *If the box above is left blank, it will be assumed that the request is indefinite.*
*Drug Name/Strength/Form (e.g., tablet, capsule):	*Quantity: *Frequency (i.e., how often, how many):
*__Generic Substitution Permitted:__ ☐ **YES** ☐ **NO** *If this field is left blank, it is assumed that the request is for what the pharmacy is processing (if applicable). If there is no pharmacy claims history, it is assumed that the request is the specific form of the drug listed in the *Drug Name field.*	
*Associated Diagnosis: *list all diagnoses and ICD-10 codes being treated with the drug.*	
*Submitting Provider NPI:	*Provider Name (First Name & Last Name):
*Provider Mailing Address (including city, state, ZIP):	
*Provider Phone:	*Provider Fax:
*Office Contact Name:	*Provider Signature:
Pharmacy Name:	Pharmacy Phone:
*Drug Allergies:	
DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)	
Drugs Tried: if quantity limit is an issue, list unit dose/total daily dose tried	**RESULTS of previous drug trials. Indicate FAILURE vs INTOLERANCE** (explain)
What is the member's current drug regimen for the condition(s) requiring the requested drug?	
If **TRANSPLANT DRUG:** Was the transplant covered by Medicare? ☐ **YES** ☐ **NO** When was the transplant? What date did you become Part A eligible? **Transplant Date:** **Part A Eligible Date:**	If **HOSPICE PATIENT:** Is medication related to the terminal condition? ☐ **YES** ☐ **NO**
HIGH-RISK MANAGEMENT OF DRUGS IN THE ELDERLY	
If the member is 65 and older, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient? ☐ **YES** ☐ **NO**	

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Please explain your reasons for appealing. Use the space below and attach additional pages, if needed. Attach any information you believe may help your case, such as a statement from your doctor and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage.

_____
_____
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_____

Signature of person requesting the appeal (the member, or the member's doctor or representative): _____

Date: _____

WellCare Health Plans, Inc., is an HMO, PPO, PDP, PFFS plan with a Medicare contract and is an approved Part D Sponsor. Enrollment in our plans depends on contract renewal.

WellCare Health Plans, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-374-4056 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-374-4056 (TTY: 711).

注愠：如果您使用繁體中文，您堯以兇費砲得語言栴助朠務。請致電1-877-374-4056 （TTY：711）

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