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:

____________________________________________________________________________________

____________________________________________________________________________________

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Please explain the reason for your appeal:

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Signature: _______________________________

WellCare
Healthy Connections

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