

Provider Payment Dispute Request Form



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. You may also fax the request if less than 10 pages to (866) 201-0657. Your appeal will be processed once all necessary documentation is received and you will be notified of the outcome.

- Child Health Plus
- WellCare Medicare
- Family Health Plus
- HealthEase Medicaid
- HealthEase Healthy Kids
- Staywell Healthy Kids

Request Date: _____
Has the service been provided yet? __ Yes __ No
Expedited Request? __ Yes __ No
(See reverse side for definition of Expedited Request)

Provider/Appellant Information

Name _____
Address: _____
City: _____

Telephone: _____
Fax: _____
Contact Person: _____

Patient Information

Name: _____
ID Number: _____
Date of Birth: _____

Service Provided Information

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

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

- | | |
|--|---|
| <input type="checkbox"/> Medical Necessity | <input type="checkbox"/> Inclusive |
| <input type="checkbox"/> Lack of Information | <input type="checkbox"/> Exclusive |
| <input type="checkbox"/> Not Prior Authorized | <input type="checkbox"/> Incidental to |
| <input type="checkbox"/> Benefits Exhausted | <input type="checkbox"/> Medicare Payment in Full |
| <input type="checkbox"/> Out of Network | <input type="checkbox"/> Claim Not Billed as Authorized |
| <input type="checkbox"/> Not a Covered Benefit | <input type="checkbox"/> Exceeds Authorization |
| <input type="checkbox"/> Untimely Filing | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Invalid Code | |

Reason for Request:

Unless your contract allows otherwise WellCare will pay the Medicare or Medicaid 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 want to appeal a claim or authorization denial. Fill out the form completely and keep a copy for your records.

***See other side for additional information**

Provider Payment Dispute Request Form



Filing on Member's Behalf

Member appeals for medical necessity, out-of-network services, or benefit denials, or services for which the member can be held financially liable for services 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 timeframe could jeopardize the life or health of the member, or the member's ability to regain maximum function.

Documentation needed: 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 mail card signed