Filing an Authorization-Related Claims Appeal for WellCare Medicare Providers

This process is for all claim denials for lack of prior authorization, services exceeding authorization, lack of supporting documentation and late notification.

Guidelines

1. WellCare encourages providers to contact the **Provider Hotline at (866) 424-4963** to resolve any issues that may arise.
2. If an issue cannot be resolved, WellCare has established a unique Claims Appeal process that permits providers to dispute WellCare's decisions on claims denials for authorization-related reasons. (A separate process exists for claims appeals that are not authorization-related.)

▷ ***Claims appeals must be filed, in writing, to the Appeals department within 90 days of the date of the Explanation of Benefits or the Provider Administrative Denial letter.***

Two ways to file:

MAIL

WellCare Health Plans Inc.
Attn: Appeals
P.O. Box 31368
Tampa, FL 33631-3368

FAX

(866) 201-0657

Authorization-Related Claims Appeals Process

Step 1 WellCare completes a thorough investigation of every Authorization-Related Claims Appeal received using applicable statutory, regulatory and contractual provisions.

Step 2 If the appeal is found lacking adequate information to make a decision, WellCare notifies the provider, in writing, of the information needed. The provider has 60 days from the date of that notification to forward the necessary information to WellCare.

Step 3 WellCare notifies the provider of the outcome of the claims appeal, in writing, via a Determination Letter within 30 business days of receiving the request. If the decision is adverse to the provider, a Provider Appeal Uphold Letter is sent to the provider.

Step 4 WellCare processes and finalizes all appealed claims to a paid or denied status within 30 business days of receipt of the appealed claim.

Please see the WellCare Provider Manual for additional information. Visit our Web site at www.wellcare.com for regular updates.