



Filing a Claims Appeal for WellCare Medicare Providers



The Claims Appeal process is designed to address claim denials for issues related to untimely filing, incidental procedures, bundling, unbundling, unlisted procedure codes, non-covered codes, etc. A separate process exists for authorization-related claims appeals.

WellCare encourages providers to **contact the Provider Hotline at (866) 687-8570** to resolve any issues that may arise before these require a formal appeal process. If an issue cannot be resolved, WellCare requests that providers follow the process outlined below.

- ▷ *Claims appeals must be submitted to the Customer Service department, in writing, within 90 days.*

Two ways to file claims appeals and documentation:

MAIL

WellCare Health Plans, Inc.
Attn: NJ Claim Appeals
P.O. Box 31412
Tampa, FL 33631-3412

FAX

(813) 262-2802

Claims Appeals Process

- Step 1** WellCare completes a thorough investigation of every claims appeal received using applicable statutory, regulatory and contractual provisions.
- Step 2** WellCare notifies the provider of the outcome of the claims appeal, in writing, with a determination letter within 30 business days of receiving the request.
- Step 3** WellCare processes and finalizes all appealed claims to a paid or denied status within 30 business days of receipt.

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