



(REDETERMINATION)

Please fax completed form and medical records to:

You may reach us by phone at 1-888-550-5252 for any questions.

Please complete each section **legibly**.

Member Name	Date of Request	Requester's Name & Relationship To Member
Health Plan ID#		STATE of Member's residence:
DOB		Physician Name
Diagnosis		Specialty
Drug Name		Contact Person
Dose		Physician's Phone
Dosage Form/Strength		Physician's Fax
Qty		Pharmacy Phone
Length of Treatment		
Clinical Reason for Appeal (include medical documentation)		
History/Allergies	Wellcare use only: RD _____ DD _____ Tech_ _____ date _____ RPh _____ date _____ MD _____ date _____	

Instructions for submitting a **MAPD Appeal Request**
(Redetermination form):

Providers may return completed forms by fax or mail.

Fax number: **1-866-201-0657**

Mailing Address:

WellCare

P.O. Box 31368

Tampa, FL 33631-3368

If providers have any questions when completing this form they should call WellCare at 1-888-888-9355 (TTY users, 1-877-247-6272), Monday – Friday 8:00am – 10:30pm EST.