

Provider Appeal Request Form

- Staywell
- Staywell Kids
- Pinellas County
- HealthEase
- HealthEase 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)

<u>Clinical Appeals Only</u>	<u>Claims Disputes Only</u>
<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
<input type="checkbox"/> Benefits Exhausted	<input type="checkbox"/> Medicare Payment In Full
<input type="checkbox"/> Out of Network	<input type="checkbox"/> Invalid Code
<input type="checkbox"/> Not a Covered Benefit	<input type="checkbox"/> Untimely Claim Filing
<input type="checkbox"/> Claim Not Billed as Authorized	<input type="checkbox"/> Non- Covered Codes
<input type="checkbox"/> Exceeds Authorization	<input type="checkbox"/> Bundling
<input type="checkbox"/> Other _____	<input type="checkbox"/> Unbundling
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. Send this form with <u>all</u> pertinent medical documentation to support the request to WellCare Health Plans, Inc. Attn: Appeals Department, P.O. Box 31368 Tampa, FL 33631-3368.	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. Send this form with <u>all</u> pertinent medical documentation to support the request to WellCare Health Plans, Inc. Attn: FL Claim Payment Disputes, P.O. Box 31370 Tampa, FL 33631-3368.

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: _____

You may also fax the request if fewer 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.

See other side for additional information.

Filing on Member's Behalf

Member appeals for medical necessity, out-of-network services benefit denials or services for which the member can be held financially liable 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 30-calendar-day time frame could jeopardize the life or health of the member or the member's ability to regain maximum function. A decision will be made within 72 hours of receipt.

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, signed mail card