Provider ER Medical Review Request Form

- O **Georgia Families®**
- O **PeachCare for Kids®**

Request Date: _______________

Provider Information

Name: ___________________________________
Address: _________________________________
City: ____________________________________
Telephone: _______________________________
Fax: _____________________________________
Contact Person: ___________________________

Patient Information

- O **Multiple Members (List on separate sheet)**

Name: _________________________________
ID Number: _____________________________
Date of Birth_____________________________
Service Provided Information
Date(s) of Service: ____________________
Place of Service: ______________________

Explanation of Issue(s):

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Fill out the form completely and keep a copy for your records. Send this form with all documentation to support the appeal request to:

WellCare of Georgia, Inc.
Attn: ER Retro Review
P. O. Box 31406
Tampa, FL 33631-3406

You may also **FAX** the request (if fewer than 10 pages) to **1-877-277-1817**.

Your request will be processed once all necessary documentation is received and you will be notified of the outcome. **Failure to submit supporting documentation may delay our response to your appeal.**

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