



# Non-Participating Provider Claim Payment Dispute Form

Visit our Provider Portal <https://provider.wellcare.com/Provider/Login> to submit your request electronically. Send this form with all pertinent medical documentation to support the request to Wellcare Health Plans, Inc.

**Attn: Claim Payment Disputes** at P.O. Box 9030, Farmington, MO 63640-9030. Your dispute will be processed once all necessary documentation is received and you will be notified of the outcome. Please fill in all provider and patient information fields below as they are **required to complete your request**.

Request Date: \_\_\_\_\_

## Provider Information

Name: \_\_\_\_\_

Provider ID on Billed Claim: \_\_\_\_\_

NPI: \_\_\_\_\_

Tax ID Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

## Patient Information

Name: \_\_\_\_\_

ID Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Service Provided Information:

Date(s) of Service: \_\_\_\_\_

Place of Service Code: \_\_\_\_\_

Claim #: \_\_\_\_\_

Authorization # (if applicable): \_\_\_\_\_

Denial Reason Code: \_\_\_\_\_

## Reason Given for Denial (from EOB or Denial letter)

No Authorization on File or Obtained

Invalid Code

Claim Not Billed as Authorized

Lack of Information

Inclusive

Exceeds Authorization

Out of Network

Exclusive

Other: \_\_\_\_\_

Not a Covered Benefit

Underpayment Dispute

*(please identify code you are appealing)*

Untimely Filing

Coordination of Benefits (COB) Dispute

**If your denial is due to Clinical Criteria Not Met, Medical Service Not Approved, Authorization Denial for Medical Criteria Not Met, Benefits Exhausted, or Not a Covered Benefit, please use the Participating Provider Reconsideration Request Form. If authorization for services is not obtained prior to services being rendered, review may be subject to an uphold of our original decision.**

*(continued)*

**Reason for Request:**

By signing this form, you agree to these terms and will not bill the member, except for applicable co-pays.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This form is to be used when you have a payment dispute. Fill out the form completely and keep a copy for your records.