

# Participating Provider Claim Payment Dispute Form



Visit our Provider Portal **provider.wellcare.com** to submit your request electronically. Send this form with all pertinent medical documentation to support the request to Wellcare. **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

Lack of Information

Out of Network

Not a Covered Benefit

Untimely Filing

Invalid Code

Inclusive

Exclusive

Underpayment Dispute

Coordination of Benefits  
(COB) Dispute

Claim Not Billed as Authorized

Exceeds Authorization

Other: \_\_\_\_\_  
(please identify code you are appealing)

**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:**

Unless your contract allows otherwise, Wellcare will pay the Medicare 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: \_\_\_\_\_

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