Participating Provider Reconsideration Request 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 By ʻOhana Health Plan. **Attn: Appeals Department** at P.O. Box 31368 Tampa, FL 33631-3368. You may also fax the request to **1-866-201-0657**. Your reconsideration 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: _____

*Only use this form if service has been rendered. Please go to the Member portal for submission and appeal form for services that have not been rendered.

Provider/Facility 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 #: _____

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

- ☐ Authorization Denied
- ☐ Medical Records Required to Support UDT Claim Billed
- ☐ Denied Medical Necessity Not Established with Information Provided
- ☐ Medical Records Required to Support Drug Test Over Limit
- ☐ Denied After Medical Review
- ☐ Radiology Service Not Service by Diagnosis. Submit Medical Records
- ☐ Other: _____ *(please identify code you are appealing)*

(continued)

If you are a Participating Provider with an appeal reconsideration, please submit your request on the Participating Provider Appeal Reconsideration Form, along with supporting documentation.

Filing on Member's Behalf Member appeals for medical necessity, out-of-network services, or benefit denials, or services for which the member can be held financially liable for services 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.

Disputed Service – Please provide service type/code(s):

Signature: _____ Date: _____

***See below for additional information**

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, nurse's 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
- **Initial Authorization Determination Letter** (if applicable)