# 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 31370 Tampa, FL 33631-3370. 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.