HURRICANE IRMA TEMPORARY CLAIMS PAYMENT EXCEPTION PROCESS

CLAIM APPEAL FORM FOR FLORIDA MEDICAID PROVIDERS

Fax this form with all pertinent information to support the request to Staywell at **1-866-201-0657**, or email to Appeals.Grievances@wellcare.com (with "Hurricane IRMA Appeal" in the subject line). If mailing, send to Staywell Health Plan of Florida, P.O. Box 31368, Tampa, Florida 33631-3368 **Attn: Appeals Dept**.

You will be notified of the outcome once all necessary documentation has been received and your appeal has been processed.

Request Date:________________

Provider/Appellant Information

Name:_____________________________________

Address:___________________________________

City/State**:**________________________________

Telephone:_________________________________

Fax/Email:__________________________________

Contact Person:_____________________________

Reason Given for Denial (from EOB)

___Lack of Prior Authorization

___Exceeds Service Limitations

___Out of Network

Patient/Claim Information

Name:______________________________

ID Number:_________________________

Date of Birth:________________________

Service Provided Information

Date(s) of Service:____________________

Place of Service:______________________

Duration of Service____________________

Claim No.____________________________

Reason for Request

Did Hurricane Irma adversely impact your ability (or the member's ability) to comply with the requirements of Staywell's policies? If so, please provide specific details, as well as include any relevant supporting documentation.

____

____

____

____

____

____

©WellCare 2017

By signing this Appeal form, you are attesting that you have been directly impacted by the Hurricane Irma in a manner that prevented following our normal health plan requirements – and submissions will be actively reviewed for potential Fraud, Waste, Abuse and other false claims violations. Each appeal submitted will be reviewed on a case-by-case basis, and submission of an appeal is not a guarantee of an overturn or payment. Staywell reserves the right to modify this form and / or documentation requirements at any time.

Signature: ______________________________________ **Date:** ______________

Filing on Member's Behalf
Member appeals 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.

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, nurses 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

©WellCare 2017