

Provider Payment Dispute Request Form



Send this form with all pertinent medical documentation to support the request to 'Ohana Health Plan
Attn: Appeals Department at P.O. Box 31368 Tampa, FL 33631-3368. You may also fax the request if less than 10 pages to (866) 201-0657. Your appeal will be processed once all necessary documentation is received and you will be notified of the outcome.

'Ohana Health Plan

Request Date: _____

Has the service been provided yet? __ Yes __ No

Expedited Request? __ Yes __ No

(See reverse side for definition of Expedited Request)

Provider/Appellant Information

Name _____

Address: _____

City: _____

Telephone: _____

Fax: _____

Contact Person: _____

Patient Information

Name: _____

ID Number: _____

Date of Birth: _____

Service Provided Information

Date(s) of Service: _____

Place of Service: _____

Reason Given for Denial (from EOB or Denial letter)

Medical Necessity

Lack of Information

Not Prior Authorized

Benefits Exhausted

Out of Network

Not a Covered Benefit

Untimely Filing

Invalid Code

Inclusive

Exclusive

Incidental to

Medicare Payment in Full

Claim Not Billed as Authorized

Exceeds Authorization

Other _____

Reason for Request:

Unless your contract allows otherwise WellCare will pay the Medicare or Medicaid 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 want to appeal a claim or authorization denial. Fill out the form completely and keep a copy for your records.

***See other side for additional information**

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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.

Expedited Request

Applies when the standard timeframe could jeopardize the life or health of the member, or the member's ability to regain maximum function.

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
- **Timely filing** - billing notes, fax confirmation, certified mail card signed