WellCare

Provider ER Medical Review Request Form

❍ **Kentucky Medicaid** **Request Date: _____**

Provider Information

Name: _____

Address: _____

City: _____

Telephone: _____

Fax: _____

Contact Person: _____

Patient Information

❍ **Multiple Members (List on separate sheet)**

Name: _____

ID Number: _____

Date of Birth_____

Service Provided Information

Date(s) of Service: _____

Place of Service: _____

Explanation of Issue(s):

_____

Fill out the form completely and keep a copy for your records. Send this form with all documentation to support the appeal request to:

WellCare of Kentucky, Inc.
Attn: **ER Retro Review**
P.O. Box 31406
Tampa, FL 33631-3406

You may also **FAX** the request (if fewer than 10 pages) to **(877) 277-1817**.
Your request will be processed once all necessary documentation is received and you will be notified of the outcome. **Failure to submit supporting documentation may delay our response to your appeal.**