



Member Appeal Request Form

Please use this form to submit your appeal request in writing. You must submit within 90 days of the date of the Notice of Action/Denial. You may attach additional sheets, if necessary.

Request Date: _____

Have the services been provided yet? __ Yes __ No

Expedited Request: __ Yes __ No * See Below

REQUESTOR INFORMATION

Name: _____

Address: _____

City: _____

Telephone: _____

Contact Person: _____

RELATIONSHIP TO MEMBER

Self *Appointed Representative Power of Attorney Parent/Guardian

*Provider *Must have written consent from member to file on member's behalf

MEMBER INFORMATION

Name: _____

Address: _____

City: _____

ID Number: _____

Date of Birth: _____

Telephone: _____

SERVICES PLANNED INFORMATION (Pre-service Request)

Who are you requesting to provide the service?

Name: _____

Address: _____

City: _____

Telephone: _____



Contact Person: _____

What date is the service planned to begin? _____

Why do you feel the planned service should be approved?

If your denial received was for a request for an out-of-network provider, why do you feel we should approve the request?

SERVICES PROVIDED INFORMATION (Retrospective request)

Complete this section only if services have already been provided.

Who provided the service(s) or who are you being billed by?

Name: _____

Address: _____

City: _____

Telephone: _____

Contact Person: _____

Date(s) of Service: _____

Please state why the services were not authorized prior to services being rendered:

I hereby request a review of the Appeal described in this document and understand that in order for the Appeal to be reviewed, WellCare of Ohio, Inc. (the Health Plan), may need medical records and other records or other information related to my Appeal. I authorize persons or entities that have any medical or other records, or knowledge of me or my dependants, to release such information to the Health Plan. Those persons or entities may include any: 1) licensed physician; 2) medical practitioner; 3) hospital, 4)



clinic or other medical or medically-related provider; 5) insurer; 6) employer; or 7) other organization, institution, or person. I specifically authorize the release of the following records or information if needed for the review of my appeal: any and all medical records and information about, associated with, or with reference to: 1) a positive test result for HIV infection; 2) AIDS; 3) alcohol or drug dependency; and 4) mental and nervous disorders.

Member or Authorized Representative's Signature

Date

You may fax to (866) 201-0657 or mail to:

WellCare of Ohio, Inc.
Attn: Appeals Coordinator
P.O. Box 31368
Tampa, Florida 33631-3368

If you have any questions, please call Customer Service at 1-800-951-7719 from 7 a.m. to 7 p.m. ET. If you need TTY/TDD services please call 1-877-247-6272.

*** Expedited Appeal:**

An appeal for a service that has not already been rendered and which taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function.

- A request for expedited Appeal submitted by your treating physician or with support from your treating physician will automatically be processed as an expedited Appeal.
- If either of these are lacking, the Plan will review your request and determine if your request should be processed as expedited. If we do not agree with your request, we will notify you and provide you with grievance rights to grieve our decision not to expedite your Appeal. Your request will then be transferred to the Standard Appeal process and a decision will be issued within 15 calendar days.

Appeal Timeframes

Standard request: 15 calendar days from receipt

Expedited request: 3-business days from receipt