



**Provider Payment Dispute Request Form**

- WellCare Medicaid
- WellCare Medicare
- HealthEase Medicaid
- HealthEase Healthy Kids
- Staywell Healthy Kids
- Child Health Plus
- Family Health Plus
- Harmony Medicaid

Request Date: \_\_\_\_\_  
 Has the service been provided yet? \_\_ Yes \_\_ No  
 Expedited Request? \_\_ Yes \_\_ No  
 (See reverse side for definition of Exp. 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. Send this form with all pertinent medical documentation to support the request to WellCare Health Plans, Inc. 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.

**\*See other side for additional information**

**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