



How to File a Claim Appeal for WellCare of Ohio Medicaid Providers

The claim appeal process is designed to address claim denials for issues related to untimely filing, incidental procedures, bundling, unbundling, unlisted procedure codes, non-covered codes, etc.

A separate appeal process is available for authorization-related claim denials.

WellCare encourages providers to contact the Provider Hotline at 1-800-951-7719 to resolve any issues that may arise prior to requesting a formal appeal.

If an issue cannot be resolved, providers may follow the appeal process outlined here.

1-800-951-7719

Monday–Friday, 7am–7pm Eastern

ohio.wellcare.com

Claim Appeal Process

1. WellCare completes a thorough investigation of every claim appeal submission using applicable statutory, regulatory and contractual provisions.
2. WellCare makes claim adjustments if the appeal is justified and a notification is sent on the Explanation of Payment (EOP). If the appeal is upheld, then a determination letter is sent to the provider.
3. WellCare processes and finalizes all appealed claims to a **paid** or **denied** status within **60 days of receipt**.

Claim appeals must be submitted to the Claims department, in writing, within 90 days of the Remittance Advice/Explanation of Benefits issue date.

Two Ways to Submit Claim Appeal Documentation:

1. By Mail

Mail written claim appeal documentation to:
WellCare Health Plans, Inc.
Attn: OH Claim Appeals
P.O. Box 31224
Tampa, FL 33631-3224

2. By Fax

Fax written claim appeal documentation to:
1-877-297-3112
Attn: OH Claim Appeals

Please see the Provider Manual for additional information.
Visit our Web site at ohio.wellcare.com for regular updates.



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