



Request for Redetermination of Medicare Prescription Drug Denial

Because WellCare Health Plans denied your request for coverage of (or payment for) a prescription drug, you have the right to an appeal. The means you may ask us to review our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for an appeal. To start the appeal, please fill out this form and send it to us by mail or fax:

Address:
WellCare Health Plans
P. O. Box 31383
Tampa, FL 33631

Fax Number:
1-866-388-1766

You may also ask us for an appeal through our website at www.wellcare.com.

Important Note: Expedited Decisions

CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS
If you have a supporting statement from your doctor, please attach it to this request.

If you or your doctor believe(s) that waiting **7 days for a standard decision** could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. We will automatically make a decision **within 72 hours** if your doctor tells us that waiting 7 days could seriously harm your health. Without your doctor's support for an expedited appeal, we will decide whether your case requires a faster decision. **Please note that you cannot ask for a faster appeal if you are asking us to pay you back for a drug you already received.**

You can ask for a faster (expedited) appeal by calling 1-888-550-5252.

Who is making this request? Provider Member Appointed Representative

Appointed Representatives: Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

Complete the following ONLY if the person making this request is not the member or prescriber:

Requestor's Name		
Requestor's Relationship to Member		
Address		
City	State	ZIP Code
Requestor Phone		

Representation documentation for requests made by someone other than member or the member's prescriber:

Attach documentation showing the authority to represent the member (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.

***REQUIRED FIELDS – ONE MEDICATION PER FORM.**

*Member Name:	
*Member ID #:	*Date of Birth:
*Member Phone:	*Duration (how long therapy lasts): Indefinite? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If the box above is left blank, it will be assumed that the request is indefinite.</i>
*Drug Name/Strength/Form (e.g., tablet, capsule):	*Quantity:
	*Frequency (i.e., how often, how many):
* Generic Substitution Permitted: <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If this field is left blank, it is assumed that the request is for what the pharmacy is processing (if applicable). If there is no pharmacy claims history, it is assumed that the request is the specific form of the drug listed in the *Drug Name field.</i>	
*Associated Diagnosis: <i>list all diagnoses and ICD-10 codes being treated with the drug.</i>	
*Submitting Provider NPI:	*Provider Name (First Name & Last Name):
*Provider Mailing Address (including city, state, ZIP):	
*Provider Phone:	*Provider Fax:
*Office Contact Name:	*Provider Signature:
Pharmacy Name:	Pharmacy Phone:
*Drug Allergies:	
DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)	
Drugs Tried: if quantity limit is an issue, list unit dose/total daily dose tried	RESULTS of previous drug trials. Indicate FAILURE vs INTOLERANCE (explain)
What is the member's current drug regimen for the condition(s) requiring the requested drug?	
If TRANSPLANT DRUG: Was the transplant covered by Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO When was the transplant? What date did you become Part A eligible? Transplant Date: Part A Eligible Date:	If HOSPICE PATIENT: Is medication related to the terminal condition? <input type="checkbox"/> YES <input type="checkbox"/> NO
HIGH-RISK MANAGEMENT OF DRUGS IN THE ELDERLY	
If the member is 65 and older, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient? <input type="checkbox"/> YES <input type="checkbox"/> NO	

