Participating Provider Reconsideration Request Form

Visit our Provider Portal **https://provider.wellcare.com/Provider/Login** to submit your request electronically. 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 **1-866-201-0657**. Your reconsideration will be processed once all necessary documentation is received and you will be notified of the outcome. Please fill in all provider and patient information fields below as they are required to complete your request.

Request Date: _____

Has the service been provided yet? ___Yes ___No

Expedited Request? ___Yes ___No **(See below for definition of Expedited Request.)**

Provider Information

Name: _____

Provider ID on Billed Claim: _____

NPI: _____

Tax ID Number: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Telephone: _____

Fax: _____

Contact Person: _____

Patient Information

Name: _____

ID Number: _____

Date of Birth: _____

Service Provided Information:

Date(s) of Service: _____

Place of Service Code: _____

Claim #: _____

Authorization # (if applicable): _____

Denial Reason Code: _____

☑ Reason Given for Denial (from EOB or Denial letter)

- ☐ Lack of Information
- ☐ Not a Covered Benefit
- ☐ Exceeds Authorization
- ☐ Benefits Exhausted
- ☐ Claim Not Billed as Authorized
- ☐ Other _____
- ☐ Out of Network

If you are a participating Provider with a payment dispute, please submit your request on Participating Provider Payment Dispute Request Form.

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Reason for Request:

Unless your contract allows otherwise, Wellcare will pay the Medicare 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 reconsider a claim for Medical Necessity, Prior Authorization, Authorization Denial, or Benefits Exhausted. Fill out the form completely and keep a copy for your records.

***See below for additional information**

Filing on Member's Behalf

Member related reconsiderations (pre-service) for medical necessity, out-of-network services, 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. This form or other office documentation must be signed and dated by the member on whose behalf you are making the reconsideration, unless you are a member's MD/DO, 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, nurse's 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