



# Participating Provider Reconsideration Request Form

Visit our Provider Portal **provider.wellcare.com** to submit your request electronically. Send this form with all pertinent medical documentation to support the request to Wellcare. **Attn: Appeals Department** at P.O. Box 31368 Tampa, FL 33631-3368. You may also fax the request 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: \_\_\_\_\_

\*Only use this form if service has been rendered. Please go to the Member portal for submission and appeal form for services that have not been rendered.

## Provider/Facility 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 #: \_\_\_\_\_

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

Authorization Denied

Medical Records Required to Support UDT Claim Billed

Denied Medical Necessity Not Established with Information Provided

Medical Records Required to Support Drug Test Over Limit

Denied After Medical Review

Radiology Service Not Service by Diagnosis. Submit Medical Records

Other: \_\_\_\_\_  
(please identify code you are appealing)

(continued)

**If you are a Participating Provider with an appeal reconsideration, please submit your request on the Participating Provider Appeal Reconsideration Form, along with supporting documentation.**

**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.

**Disputed Service – Please provide service type/code(s):**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*See below for additional information**

**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
- **Initial Authorization Determination Letter** (if applicable)