Non-Participating Provider Claim Payment Dispute 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 Health Plans, Inc. **Attn: Claim Payment Disputes** at P.O. Box 31370 Tampa, FL 33631-3370. Your dispute 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:	
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Provider ID on Billed Claim: ID Number: NPI:	Provider Information	Patient Information	
NPI:	Name:	Name:	
Tax ID Number:	Provider ID on Billed Claim:	ID Number:	
Tax ID Number:	NPI:	Date of Birth:	
Address:	Tax ID Number:		
City: Date(s) of Service: State: Zip Code: Telephone: Place of Service Code: Telephone: Claim #: Fax: Authorization # (if applicable): Contact Person: Denial Reason Code: Contact Person: Denial Reason Code: Mo Authorization on File Invalid Code or Obtained Inclusive Lack of Information Exclusive Out of Network Underpayment Dispute Not a Covered Benefit Coordination of Benefits Untimely Filing (COB) Dispute	Address:	Service Provided Information:	
State: Zip Code: Telephone: Telephone: Fax: Contact Person: Contact Person: Denial Reason Code:		Date(s) of Service:	
Fax:		Place of Service Code:	
Contact Person: Denial Reason Code: Reason Given for Denial (from EOB or Denial letter) No Authorization on File or Obtained Lack of Information Out of Network Out of Network Out of Network Out a Covered Benefit Outimely Filing Denial Reason Code: Claim Not Billed as Authorized <	Telephone:	Claim #:	
Reason Given for Denial (from EOB or Denial letter) No Authorization on File Invalid Code or Obtained Inclusive Lack of Information Exclusive Out of Network Underpayment Dispute Not a Covered Benefit Coordination of Benefits Untimely Filing COB) Dispute	Fax:	Authorization # (if applicable):	
No Authorization on File Invalid Code Claim Not Billed as Authorized or Obtained Inclusive Exceeds Authorization Lack of Information Exclusive Other:	Contact Person:	Denial Reason Code:	
Out of Network Underpayment Dispute (please identify code you are appealing) Not a Covered Benefit Coordination of Benefits (COB) Dispute	 No Authorization on File Invalid Code Obtained Inclusive 	Claim Not Billed as Authorized Exceeds Authorization	
If your denial is due to Clinical Criteria Not Met. Medical Service Not Approved. Authorization	Out of Network Underpaymen Not a Covered Benefit Coordination of COB) Dispute	t Dispute (please identify code you are appealing) of Benefits	

If your denial is due to Clinical Criteria Not Met, Medical Service Not Approved, Authorization Denial for Medical Criteria Not Met, Benefits Exhausted, or Not a Covered Benefit, please use the Participating Provider Reconsideration Request Form. If authorization for services is not obtained prior to services being rendered, review may be subject to an uphold of our original decision.

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By signing this form, you agree to these terms and will not bill the member, except for applicable co-pays.

Signature:	Dat	e:
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This form is to be used when you have a payment dispute. Fill out the form completely and keep a copy for your records.