Provider Administrative Review Request Form

Request Date: ________________

Providers may file appeals or disputes based on claim outcome within 120 days from date of remittance advice or EOP. Fill out the form completely and keep a copy for your records. Your appeal or dispute will be processed once all necessary documentation is received. Please allow 30 days for a response. If all necessary documentation is not received, a response may surpass the 30 day timeframe.

Skilled Nursing Facility
Hospital
Home and Community Based Providers (Foster Home, Home Care, etc…)
Physician/Allied Health Practitioners
Other Health Care Providers (Lab, DME, etc…)

Provider/Appellant Information

Name: ___________________________________

Provider # _______________________________

Tax ID # ________________________________

Telephone: ______________________________

Fax: ___________________________________

Contact Person: ___________________________

Patient Information

Name: ____

'Ohana Member #: _________ Date of Birth: ___________

Service Provided Information

Date(s) of Service: ____________ Place of Service: ______

Claim(s) Number: ________________________________

Authorization Number: ____________________________

√ Reason Given for Denial or Underpayment (from EOP or denial letter)

Clinical Appeals Only:	Claims Disputes Only:	Claims Coding Disputes Only:
__ Medical Necessity	__ Inclusive/Exclusive	__ Claim Denial begins with "IH"
__ Lack of Information	__ Exclusive	__ Claim Denial begins with "MK"
__ No Prior Authorization	__ Incidental Procedures	__ Claim Denial begins with "PD"
__ Benefits Exhausted	__ Bundling / Unbundling	
__ Out of Network	__ Time Limit for filing expired	
__ Not a Covered Benefit	__ Unlisted Procedure Codes	
__ Exceeds Authorization	__ Non-covered Code (NOFEE)	
__ Other:	__ EOB Required from Primary Payer	
__ Retro Eligibility	__ Other _________________	
__ Post Service Review	__ Invalid COB payment received	
	__ Claim Payment Underpaid	
Providers may seek an appeal within 120 calendar days of claims denial. Send this form with all pertinent medical documentation	Claim payment disputes must be submitted in 120 days of the date of denial on the EOB. To initiate this process, please mail or	Inquiries related to **Explanation of Payment Codes and Comments** beginning with **IH**XXX, **MK**XXX, or **PD**XXX

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to support the request to WellCare Health Plans, Inc., Attn: **Appeals Department**, P.O. Box 31368Tampa, FL 33631-3368. You may also fax the request if fewer than 10 pages to (866) 201-0657.	fax this form and supporting documentation to ‘Ohana Health Plan, **Claim Payment Disputes**, PO BOX 31370 Tampa, FL, 33631-3372. Fax (877) 277-1808	should be sent to: Payment Policy Disputes Department, PO BOX 31426 Tampa, FL 33631-3426.

Reason for Request:

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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: ________________________________ Date: ___________________

Clinical Appeals Only:

Filing on Member’s Behalf

Member appeals for medical necessity, out-of-network services benefit denials or services for which the member can be held financially liable 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.

Expedited Request

Applies when the standard 30-calendar-day time frame could jeopardize the life or health of the member or the member’s ability to regain maximum function. A decision will be made within 72 hours of receipt.

Required Attachments: All Medical Information Needed to Determine Medical Necessity. Examples:

Inpatient or observation stays–doctor orders, progress notes, ER notes, medication record, lab reports, nurses 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, signed mail card
EOB Required from Primary Payor- explanation of payment or remittance advice from primary payor