

MEDICARE REDETERMINATION REQUEST FORM

1. Beneficiary's Name: _____
2. Medicare Number: _____
3. Description of Item or Service in Question: _____
4. Date the Service or Item was Received: _____
5. I do not agree with the determination of my claim. MY REASONS ARE:

6. Date of the initial determination notice _____
(If you received your initial determination notice more than 120 days ago, include your reason for not making this request earlier.)

7. Additional Information Medicare Should Consider: _____

8. Requester's Name: _____
9. Requester's Relationship to the Beneficiary: _____
10. Requester's Address: _____

11. Requester's Telephone Number: _____
12. Requester's Signature: _____
13. Date Signed: _____
14. I have evidence to submit. (Attach such evidence to this form.)
 I do not have evidence to submit.

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.

Instructions for submitting a **Medicare Redetermination** request form:

Members may return completed forms by fax or mail.

Fax number: **1-866-388-1766**

Mailing Address:

**WellCare
PDP Appeals
P.O. Box 31383
Tampa, FL 33631-3383**

If members have any questions when completing this form, they should call WellCare at 1-888-550-5252 (TTY/TDD users call 1-888-816-5252), Monday – Sunday, 7:00am – 2:00am Eastern.