



‘Ohana Appeal Request

*Please fax request to 1-813-262-2907 along with all pertinent medical records.
You may reach us by phone at 1-888-505-1201 for any questions
Please complete each section legibly.*

The appeal request is being initiated by (please select only one option):

Physician
 Member
 Appointed Representative

Member’s Name:	Date & Time of Request:	Name person requesting this appeal and their relationship to the member:
‘Ohana ID#:		Original Coverage Determination Date:
Date of Birth:		Ticket #:
Member’s Phone Number:		Requestor’s Phone Number:
Member’s Address:		Requestor’s address: <i>(if applicable)</i>
Diagnosis:		Requestor’s Fax Number: <i>(if applicable)</i>
Medication Name:		Physician’s Name:
Medication Strength & Dose:		Contact Person at Physician’s office:
Quantity and Day Supply:		Physician Phone:
Length of Treatment being requested:		Physician Fax:
Clinical Reason for Appeal (include medical documentation)		
History/Allergies		‘Ohana USE ONLY ‘Ohana Associate Name: _____ ‘Ohana Associate Location: _____

REQUEST FOR EXPEDITED REVIEW (72 HOURS)

BY CHECKING THIS BOX, THE PRESCRIBING PHYSICIAN INDICATED ABOVE OR PHYSICIAN’S AGENT CERTIFIES THAT APPLYING THE 7 DAY STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER’S ABILITY TO REGAIN MAXIMUM FUNCTION.

‘Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.