

# Participating Provider Payment Dispute Form



Visit our Provider Portal <https://provider.wellcare.com/Provider/Login> to submit your request electronically. Send this form with all pertinent medical documentation to support the request to Wellcare Health Plans, Inc.

**Attn: Appeals Department** at P.O. Box 31368 Tampa, FL 33631-3368. 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: \_\_\_\_\_

## Provider 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 # (if applicable): \_\_\_\_\_

Denial Reason Code: \_\_\_\_\_

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

Lack of Information

Invalid Code

Coordination of Benefits  
(COB) Dispute

Out of Network

Inclusive

Claim Not Billed as Authorized

Not a Covered Benefit

Exclusive

Exceeds Authorization

Untimely Filing

Underpayment Dispute

Other \_\_\_\_\_

**\*If your denial is due to Medical Necessity, Prior Authorization, Authorization Denial, or Benefits Exhausted, please use the Participating Provider Reconsideration Request Form.**

*continued on next page*

**Reason for Request:**

---

---

---

---

---

---

---

---

---

---

Unless your contract allows otherwise, Wellcare will pay the Medicare allowable, depending on member's plan, for the service performed if we overturn our previous decision. By signing this form, you agree to these terms and will not bill the member, except for applicable co-pays.

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

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