CLAIM DISPUTE FORM

Use this form to file a Wellcare Claim Dispute. All fields are required information. This form should be used only when a Provider disagrees with the outcome of a Request for Reconsideration.

All requests for corrected claims, reconsiderations or claim disputes must be received within 365 days from the date of explanation of payment or denial is issued.

All fields in the box immediately below are required information

Provider Name	Provider Tax ID#
Claim ID#	Reconsideration ID#
Member Name	Date(s) of Service

Describe in detail why you disagree with the prior claim reconsideration request outcome:

_____

_____

_____

Date of Request: _____

Provider Name: _____

Requestor Phone Number: _____

Requestor Email Address:_____

ATTACH: A Copy of the EOP(s) with Claim(s) to be adjusted clearly circled along with the response to your original request for reconsideration. The documentation must also include a detailed description of the reason for the request and any additional supporting documentation.

Mail completed form(s) and attachments to:

Wellcare
Attn: Dispute
PO Box 4000
Farmington, MO 63640
Fax (833) 957-0438

Wellcare will make reasonable efforts to resolve all requests within 30 calendar days of receipt.