# PROVIDER
# PAYMENT RECONSIDERATION/DISPUTE FORM

**Date:** ____________________

☐ **Contracted Provider** ☐ **Non-Contracted Provider**

**Please complete the following form to help expedite the review of your claims reconsideration.**

Is this a:

☐ **Request for Reconsideration**: You disagree with the original claim outcome (payment amount, denial reason, etc.) Please check if this is the first time you are asking for a review of the claim.

☐ **Claim Dispute**: You disagree with the outcome of the Request for Reconsideration.

| **Provider Name*** | **Provider Tax ID*** |
|---|---|
| **Provider NPI*** | **Date of Last Explanation of Payment** |
| **Wellcare by Allwell Claim Number*** | **Date of Service*** |
| **Member Name** | **Member ID** |

* Indicates a required field

Reason for the reconsideration/dispute (please check all that apply):

☐ Claim was denied for no authorization, but authorization number was obtained.

☐ Claim was denied for no authorization, but no authorization is required for this service.

☐ Claim was denied for member not being eligible, but member was eligible on date of service (attach eligibility information.)

☐ Claim was not paid per the terms of my contract with Wellcare (attach relevant reimbursement section.)

☐ Claim was denied "Past Timely Filing" (attach proof of timely filing.)

☐ Claim was paid the incorrect amount (include calculation of expected payment and supporting information.

☐ Other: Please explain:

______________________________________________________________________

______________________________________________________________________

Please ensure sufficient detail is provided to assist us in the review of your reconsideration or dispute. A copy of the Explanation of Payment (EOP) and supporting documentation must be submitted with the request. *Non-contracted providers must also submit a completed and signed Waiver of Liability (WOL), a copy of which may be found on our website at allwell.absolutetotalcare.com.

Mail completed forms and all attachments to:

**Wellcare by Allwell**
**Medicare Grievance & Appeals Department**
**P.O. Box 3060**
**Farmington, Missouri 63640-3800**

Contact Name and Number of Person Requesting the Appeal: ______________________________