

Provider Appeal Request Instructions

This packet is designed to assist you in requesting an appeal for a claim or authorization denial for behavioral health services. Please follow the instructions below when requesting an appeal.

There are 2 types of appeal available: Standard or Expedited.

Standard Appeals are for services that have already been rendered or for services that are not emergently or urgently needed.

Expedited Appeals are for circumstances when waiting the standard timeframe for an appeal determination could jeopardize the life or health of the member, or the member's ability to regain maximum function. Expedited appeals are only used for pre-service appeals. This includes situations where a denial has been issued and member remains on an inpatient unit.

Appeal Request Forms: In this packet, you will find separate forms for requesting a standard appeal (page 2) or an expedited appeal (page 3). Each form contains specific submission guidelines. Use of these forms is not required, but will help ensure prompt resolution.

If you do not use the appeal request forms, you must provide a signed cover letter with the following minimum information:

- A request for appeal or reconsideration of a denial,
- Your name, address, and phone number;
- The member's name, DOB, and policy number;
- Dates and types of services requested, and the provider rendering the service;
- Reason that you are requesting appeal or believe denial should be overturned.

Appeal requests that do not contain sufficient information will not be processed.

If you choose not to use the expedited appeal request form and would like to request an expedited appeal, you must clearly communicate in the cover letter that you are requesting expedited status.

Supporting Documentation: All appeal requests should include clinical documentation and other pertinent information that supports the need for the requested service. For examples, see page 2.

Submission Deadlines: In most cases, providers have 90 days from the initial notice of denial to file a request for appeal. Please check your denial notice, contract, and provider handbook for details.

Appeals Address: The address for submission is on page 2 or 3, depending on type of appeal. Please include the word "Appeals" in the address line for correct routing and prompt resolution.

Non Network Providers: If you are not a WellCare/ Harmony network provider- and you have not completed a single case agreement- you must complete and send the Waiver of Liability Form on page 4 in order for your appeal to be processed. This applies only to Medicare members. If you have completed a single case agreement, please include a copy with your appeal.

Appeal Outcomes: An appeal determination letter will be mailed to the appealing party for all processed appeals. We do not take routine verbal requests for status updates.

Claims Appeals: This appeal packet is for appeals of services where authorization was denied or claims were not paid as a result of lack of authorization. If you are seeking to appeal the specific amount that was paid on a claim (that is unrelated to whether the service was authorized), or contest a claim denial for untimely filing, then please address your appeal directly to: WellCare Claims Appeals, P O Box 31372, Tampa, FL 33631-3372. If further authorization is required to effect claims payment, then please use the appropriate address below.

STANDARD APPEAL REQUEST FORM

Behavioral Health Only

Provider/Appellant Information

Provider Name: _____

Contact Person: _____

Address: _____

City, St. Zip: _____

Telephone: _____

Patient Information

Name: _____

ID Number: _____

Date of Birth: _____

Services Provided

Date(s) of Service: _____

Type of Service: _____

Reason for requested overturn of denial:

Unless your contract allows otherwise WellCare will pay the Medicare or Medicaid 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: _____

Print name: _____ Phone Number: _____

The Appeal Determination will be mailed to the person/ address on this form or the appeal letter.

Required Documentation:

1. Appeal Request: This completed form, or a signed letter with your name, address, and phone number; the member's name, DOB, policy number, dates and types of services requested, and reason that you believe denial should be overturned.

2. All Medical Information Needed to Determine Medical Necessity - Examples:

Inpatient or Observation stays- Doctor orders, progress notes, ER notes, medication record, lab reports, nurses notes, consultation reports, admission and discharge summaries.

Outpatient Services- Evaluations and treatment plan, progress notes, treatment plan reviews, MD notes.

Consultations- consultation report, Referring MD script

Timely filing- billing notes, fax confirmation, certified mail receipt with signature and identifying information.

Please fax your appeal to:

(800) 778-8231 (This is a secure fax, with access limited to WellCare Appeals staff).

Or you can mail to:

**Harmony Behavioral Health Appeals
P.O. Box 31402
Tampa, FL. 33631-3402**

For overnight, certified, or ground delivery:

**Harmony Behavioral Health Appeals
8735 Henderson Rd.
Tampa, FL. 33634**

If you would like to submit the appeal electronically, you must contact us first at 877 712-5340, ext 3694 to ensure HIPAA compliance. Files must be encrypted and in Word, pdf, or comparable file format.

EXPEDITED APPEAL REQUEST FORM

Expedited Appeals are available only when waiting the standard timeframe for an appeal decision could jeopardize the life or health of the member, or the member's ability to regain maximum function. Expedited appeals must be requested by the physician ordering or providing the requested services.

Expedited appeals are not available for services that have already been rendered. Please use Standard appeal form for previously provided services.

Provider/Appellant Information

Patient Information

Provider Name: _____

Name: _____

Contact Person: _____

ID Number: _____

Phone: _____

Date of Birth: _____

Who is the physician requesting expedited status? (Print name) _____

Phone number the physician can be reached at for additional information: _____

Please indicate available times or specific instructions for reaching the physician: _____

Please ensure that the physician is available / willing to discuss the case. If the physician cannot be reached, the appeal will be determined based upon existing and submitted information.

Is member currently inpatient? Yes No

If yes, what is the name of the hospital/ facility? _____

Anticipated discharge date (if applicable) _____

How will waiting the standard timeframe for appeal resolution jeopardize the health or safety of the member? (this can be done on an attachment) _____

By signing this form, I attest that the above information is true and accurate to the best of my knowledge.

Signature _____ Date _____

If you choose not to use this form and would like to request an expedited appeal, you must clearly state in a signed cover letter that you are requesting expedited status, and provide at a minimum, your name and phone number, the requesting physician's name and phone number, the member's name, ID, and the services being requested.

If your appeal request is not granted expedited status, it will be processed as a standard appeal unless you withdraw your request. We will notify you if request for expedited processing is denied.

The expedited appeal determination will be communicated verbally to the physician or contact person, and followed by written notification.

Please include this form (or information above) and any information that supports need for expedited review.

FAX ALL EXPEDITED REQUESTS TO:
(813) 262-2907



Waiver of Liability Statement

Under Medicare guidelines, non-contracted providers are required to sign a waiver of liability to ensure WellCare members are held harmless for plan responsibility cost sharing amounts. Please fill out the Waiver of Liability Statement in order for your appeal to be processed and include it with your appeal. Under Medicare guidelines, if a provider refuses to sign a waiver of liability, the Health Plan will forward the appeal request to Maximus, a Medicare contracted organization, to review for dismissal.

Enrollee's Name

Enrollee's HICN (Medicare) #

Provider

Dates of Service(s)

WellCare HMO
Health Plan

I hereby waive any right to collect payment from the above mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42CFR 422.600.

Signature

Date