

Today's Options® PPO/PFFS

A WellCare Company

Provider Dispute Resolution Request Form

Instructions:

Please fully complete the form. Information with an asterisk (*) is required. Be specific when completing the Description of Dispute and Expected Outcome. Please provide supporting documentation to support your appeal.

Mail the completed form to: **Provider Dispute Resolution**
Today's Options
P.O. Box 18500
Austin, TX 78760-8500

Or fax the complete form to: 1-877-656-1728

Provider Name:

Provider Tax ID#/Medicare ID#:

Address:

Provider Type: MD Mental Hospital Hospital ASC SNF
 DME Home Health Rehab Ambulance
 Other _____ (Please specify)

Claim Information Single Multiple "LIKE" Claims (Please provide listing)
Number of claims _____

*Patient Name:

*Date of Birth:

*Health Plan ID #:

Patient Account Number:

Original Claim ID Number
(if multiple cases provide separate listing):

*Service From/To Date:

Original Claim Amount Billed:

Original Claim Amount Paid:

Dispute Type:

Claim Seeking Resolution of Billing Determination
 Appeal of Medical Necessity Other
 Requirement for Reimbursement of Overpayment

*Description of Dispute:

*Expected Outcome:

Contact Name (Please Print)

(____) _____

Contact Name (Please Print)

(____) _____

Check if additional information is attached.