Appeals/Reconsiderations (Medical) and Grievances Guide

The **Provider Portal** is the fastest way to submit Appeals and check status. You can also check status of Appeals by calling Provider Services.

APPEALS AND RECONSIDERATIONS (MEDICAL)

APPEALS (NON-PARTICIPATING PROVIDERS AND MEMBERS)

Procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes they are entitled to receive.

RECONSIDERATIONS (PARTICIPATING PROVIDERS)

A reconsideration is the first appeals process level. Reconsiderations involved an MA plan reviewing an adverse organization determination, the findings they based them on, along with other evidence.

All non-participating Medicare provider appeals must be submitted within **65 calendar days from the date of the notice of the initial determination** and they must also submit a signed waiver of liability (WOL) with their request for processing. Accompanying the WOL, an Appointment of Representative form is needed for the WOL process whenever a vendor (such as a billing entity) is appealing on behalf of a non-participating provider. When submitting an appeal, the specific code or service being appealed must be listed on the appeal form. Anything else related to authorization or medical necessity that is in question should be sent to the Appeals P.O. Box. Include all substantiating information (please do not include image of claim) like a summary of the appeal, relevant medical records and member-specific information.

Participating providers must seek a reconsideration through the Appeals Department within **90 calendar days** (required timing is listed in your contract) of a claim denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification. When submitting a reconsideration, the specific code or service being reconsidered must be listed on the appeal form. Anything else related to authorization or medical necessity that is in question should be sent to the Appeals P.O. Box. Include all substantiating information (please do not include image of claim) like a summary of the appeal, relevant medical records and member-specific information.

APPOINTMENT OF REPRESENTATIVE (AOR)

With the Member's written consent, an appeal for denial of an authorization for medical service/Part B Drug can be filed on the Member's behalf by a participating Physician who has or is currently treating the Member. If the Member wishes to use a representative, they must complete a Medicare AOR form, ***or an equivalent written notice***. The Member and representative must sign the AOR form.

The appeal will not be considered valid until the AOR documentation is provided. AOR Forms can be found on the plan website, under *Forms*.

Non-Physician (Practitioner): Per CMS and the Social Security Act, a non-physician is not a qualified physician (e.g.).

Type of Practitioner*	AOR Needed	No AOR Needed
Certified Nurse Midwife (CNM)	X	
Certified Registered Nurse Anesthetist (CRNA)	X	
Clinical Nurse Specialist (CNS)	X	
Surgeon Assistant	X	
Anesthesiology Assistant	X	
Audiologist	X	
Licensed Clinical Social Worker (LCSW)	X	
Clinical Psychologist	X	
Non-Clinical Psychologist	X	
PT, OT, Speech Pathologist	X	
Registered Dietician or Nutrition Professional	X	
Advanced Registered Nurse Practitioner (ARNP)	X	
Nurse Practitioner (NP)	X	
Physician Assistant (PA)	X	

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APPEALS AND RECONSIDERATIONS (MEDICAL) CONTINUED

Physician: A person skilled in the art of healing; specifically, one educated, clinically experienced, and licensed to practice medicine as usually distinguished from surgery. A person licensed to practice medicine; a medical director (e.g.).

Type of Physician*	AOR Needed	No AOR Needed
Doctor of Medicine (MD)		X
Doctor of Osteopathic Medicine (DO)		X
Doctor of Dental Surgery (DDS) or Dental Medicine (DMD)		X
Doctor of Optometry (OD)		X
Doctors of Obstetrics and Gynecology (OB-GYN)		X
Chiropractor (Doctor of Chiropractor)		X
Psychiatrist		X

Provider: Any physician, hospital, facility, or other Health Care Professional who is licensed or otherwise authorized to provide Health Care services in the State or jurisdiction in which they are furnished.

Type of Facility*	AOR Needed	No AOR Needed
Inpatient		X
Behavioral Inpatient		X
Home Health Agency	X	
Skilled Nursing Facility on own behalf		X
Skilled Nursing Facility (PT, OT & ST)	X	
Physician Group on own behalf		X
Physician Group (PT, OT & ST)	X	
Rehabilitation Facility (i.e., LTAC)		X
Durable Medical Equipment	X	

*The above lists of Non-Physicians, Physicians and Providers is not intended to be an all-inclusive list, they are the most common identified on an appeal.

MAIL OR FAX ALL MEDICAL APPEALS AND RECONSIDERATIONS WITH SUPPORTING DOCUMENTATION TO:

AR, CT, FL, GA, HI, IL, KY, LA, ME, MI, MO, MS, NC, NJ, NY, SC, TN, TX, WA	**Wellcare** **Attn: Appeals Department** **P.O. Box 31368** **Tampa, FL 33631-3368**
AZ, DE, IA, IN, KS, NE, NV, OH, OK, PA, WI	**Wellcare** **Attn: Appeals Department** **P.O. Box 3060** **Farmington, MO 63640-3060**

Fax: 1-866-201-0657

Plan websites can be accessed by visiting **wellcare.com/providers** and selecting your state.

NOTE: Wellcare does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.

GRIEVANCES

Member grievances may be filed verbally by contacting Customer Service or submitted in writing via mail, email or fax. Providers may also file a grievance on behalf of the member with the member's written consent, AOR forms are available on the plan website, under *Forms*.

MAIL, EMAIL OR FAX ALL MEMBER GRIEVANCES TO:

AR, CT, FL, GA, HI, IL, KY, LA, ME, MI, MO, MS, NC, NJ, NY, SC, TN, TX, WA	**Wellcare Attn: Grievance Department P.O. Box 31384 Tampa, FL 33631-3384**
AZ, DE, IA, IN, KS, NE, NV, OH, OK, PA, WI	**Wellcare Attn: Grievance Department P.O. Box 10450 Van Nuys, CA 91410-0450**

Email: Please visit the Contact Us page on the website.

Fax: 1-866-388-1769