



# Provider Appeal Request Form

- Harmony Health Plan
- HealthEase
- Healthy Kids
- Staywell
- WellCare Choice
- WellCare Commercial

Request Date: \_\_\_\_\_  
 Has the service been provided yet?  Yes  No  
 Expedited Request?  Yes  No  
 (See reverse side for definition of Expedited Request)

### Provider/Appellant Information

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_

### Patient Information

Name: \_\_\_\_\_  
 ID Number: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

### Service Provided Information

Date(s) of Service: \_\_\_\_\_  
 Place of Service: \_\_\_\_\_

### √ Reason Given for Denial (from EOB or denial letter)

- |  |   |
|--|---|
| <input type="checkbox"/> Medical Necessity     | <input type="checkbox"/> Inclusive                      |
| <input type="checkbox"/> Lack of Information   | <input type="checkbox"/> Exclusive                      |
| <input type="checkbox"/> Not Prior Authorized  | <input type="checkbox"/> Incidental                     |
| <input type="checkbox"/> Benefits Exhausted    | <input type="checkbox"/> Medicare Payment In Full       |
| <input type="checkbox"/> Out of Network        | <input type="checkbox"/> Claim Not Billed as Authorized |
| <input type="checkbox"/> Not a Covered Benefit | <input type="checkbox"/> Exceeds Authorization          |
| <input type="checkbox"/> Untimely Filing       | <input type="checkbox"/> Other: _____                   |
| <input type="checkbox"/> Invalid Code          |   |

### Reason for Request:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Unless your contract allows otherwise, Harmony 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: \_\_\_\_\_

This form is to be used when you want to appeal a claim or authorization denial. Fill out the form completely and keep a copy for your records. Send this form with all pertinent medical documentation to support the request to Harmony Health Plan, Attn: **Appeals Department**, P.O. Box 31368 Tampa, FL 33631-3368. You may also fax the request if fewer than 10 pages to (866) 201-0657. Your appeal will be processed once all necessary documentation is received and you will be notified of the outcome.

See other side for additional information.

### **Filing on Member's Behalf**

Member appeals for medical necessity, out-of-network services benefit denials or services for which the member can be held financially liable must be accompanied by an Appointment of Representation form or other office documentation signed and dated by the member you are appealing on behalf of, unless you are an attorney, power of attorney, court appointed guardian or health care proxy agent with associated documentation.

### **Expedited Request**

Applies when the standard 15-business-day time frame could jeopardize the life or health of the member or the member's ability to regain maximum function. A decision will be made within 72 hours of receipt.

### **Documentation needed: 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, PT/OT/ST notes (if applicable)

**Procedures**—procedure report, supporting consultation reports, PCP progress notes, referring MD script

**Consultations**—consultation report, referring MD script

**PT, OT, ST**—progress notes, evaluations, summaries, Referring MD script

**Radiology**—reports, referring MD script

**Timely filing**—billing notes, fax confirmation, certified, signed mail card