COVER SHEET

PFFS Provider Claim Payment Resolution Form

If you believe that the payment amount you received for a service is less than the amount indicated in the WellCare Private Fee-for-Service (PFFS) terms and conditions of payment, you have the right to dispute the payment amount by following our dispute resolution process. To view all the details of the process visit www.wellcarepffs.com/provider/claiminformation.

To file a payment dispute with us, complete and send this form with a copy of the claim being disputed and all appropriate documentation to support your payment dispute, e.g., the remit and any information that Original Medicare would pay differently for the service on the claim.

Claims must be disputed within 120 days from the date payment is initially received by the provider.

Mail to: WellCare Health Plans, Inc., P.O. Box 4438, Scranton, PA 18505 or **Fax to:** 1-866-473-9122

Request Date:			
Member			
Member ID:	Date of Birth:		
Member Last Name:	Member First Name:		
Requesting Provider			
Provider/Facility Name:	Tax ID Number:		
Phone Number:	Fax Number:		
Address:	City:	State:	Zip:
Contact Person:	Contact Phone:		
Claim Information			
Date(s) of Service:	Total Billed Charge:		
Claim Number(s):			
Explanation of Issue(s)			