

2009

Medicare Advantage Private Fee-For-Service Plan Provider Resource Guide



Table of Contents

INTRODUCTION | Section 1

- About Us | Section 1A
- Mission Statement and Core Values | Section 1B
- How to Contact Us | Section 1C

SERVICE AREA | Section 2

QUESTIONS AND ANSWERS ABOUT WELLCARE PRIVATE FEE-FOR-SERVICE | Section 3

ENROLLMENT AND ELIGIBILITY | Section 4

- Eligibility Verification | Section 4A
- Identification Card | Section 4B
- Plan Benefits | Section 4C
- Non-discrimination in Delivery of Health Services | Section 4D
- Member Rights Under Medicare | Section 4E
- Advance Directives | Section 4F
- Member's Participation in Decision Making | Section 4G
- Member Case Management | Section 4H
- Authorization and Review Rules Notification | Section 4I
- Provider Advice to Members Regarding Health Care Options | Section 4K

PROVIDER INFORMATION | Section 5

- How to Participate | Section 5A
- Terms and Conditions of Payment | Section 5B
- Medical Records | Section 5C
- Confidentiality of Member Information and Release of Records | Section 5D

PAYMENT AND CLAIMS INFORMATION | Section 6

- Submission of Claims | Section 6A
- Provider Claim Payment Dispute Resolution Process | Section 6B
- Provider Appeal for Medical Necessity and/or Benefits Process | Section 6C

APPEALS AND GRIEVANCES | Section 7

- Member Appeals Process | Section 7A
- Member Grievances | Section 7B
- Quality of Care Issues | Section 7C

PHARMACY | Section 8

BEHAVIORAL HEALTH | Section 9

QUALITY IMPROVEMENT | Section 10

FRAUD AND ABUSE | Section 11

MARKETING GUIDELINES | Section 12

FORMS | Section 13

INTRODUCTION | Section 1

The Balanced Budget Act of 1997 created Private Fee-for-Service (PFFS) plans as a private plan option for Medicare beneficiaries. PFFS plans are Medicare Advantage plans offered by a private insurance company, and that company pays providers instead of Medicare for the Medicare portion of claims. PFFS plans are not Medicare supplements, Medigap, Medicare HMO or Prescription Drug Plans. PFFS plans allow members to use any provider—such as a physician, health professional, hospital or other Medicare provider in the United States—who agrees to treat the member after having the opportunity to review the plan’s terms and conditions of payment (www.wellcarepffs.com/provider/terms), as long as the provider is eligible to provide health care services under Medicare Part A and Part B (also known as ‘Original Medicare’) or is eligible to be paid by WellCare PFFS for benefits that are not covered under Original Medicare.

The PFFS plans offered by WellCare Health Plans, Inc., for 2009 are identified by the following names:

- WellCare Concert
- WellCare Melody
- WellCare Melody-Plus
- WellCare Prelude
- WellCare Quartet
- WellCare Serenade
- WellCare Sonata
- WellCare Sonata-Plus

This *Provider Resource Guide* is presented to WellCare PFFS non-network providers to assist with the administration and understanding of our PFFS plans, services, policies and procedures.

WellCare prides itself on providing industry-leading service to members and providers. We work hard to ensure that providers receive comprehensive, up-to-date information, best-in-class service and timely and accurate claims payment.

We hope that along with the WellCare PFFS Web site—www.wellcarepffs.com—and *Quick Reference Contact Guide*, you will find this *Provider Resource Guide* a useful tool. We look forward to supporting you!

About Us | Section 1A

Who is WellCare?

WellCare provides managed care services targeted exclusively to government-sponsored health care programs, focused on Medicaid and Medicare, including prescription drug plans and health plans for families, and the aged, blind and disabled. As of June 30, 2009, we served nearly 2.4 million members. We believe that this broad range of experience and exclusive government focus allow us to efficiently and effectively serve our members and providers and to manage our operations.

Founded in 1985 with three associates, WellCare grew to more than 800 associates and 467,000 members in Florida, New York and Connecticut by 2002. In 2004, the Company acquired Harmony to enter the Midwest and became publicly traded. By 2006, WellCare served 2.2 million members as it became a national PDP provider and the largest Medicaid plan in Georgia. Today WellCare has grown to be the eighth-largest publicly traded health care plan in the country with 3,800 associates and nearly 2.4 million members nationwide.

Mission Statement and Core Values | Section 1B

Vision

To be the leader in government sponsored health care programs in partnership with the members, providers, governments and communities we serve.

Mission Statement

WellCare will:

1. Enhance our members' health and quality of life;
2. Partner with providers and governments to provide quality, cost-effective health care solutions and
3. Create a rewarding and enriching environment for our associates.

Core Values

Partnership

Members are the reason we are in business; providers are our partners in serving our members; and regulators are the stewards of the public's resources and trust. We will deliver excellent service to our partners.

Integrity

Our actions must consistently demonstrate a high level of integrity that earns the trust of those with whom we work and serve.

Accountability

All associates must be responsible for the commitments we make and the results we deliver.

Teamwork

With our fellow associates, we can expect—and are expected to demonstrate—a collaborative approach in the way we work.

How to Contact Us | Section 1C

We have a dedicated team to support providers in our Provider Service Center as well as a Provider Relations department. To contact our Provider Service Center, call 1-866-235-2770 (TTY/TDD: 1-866-239-6265) Monday–Sunday, 7am to 2am Eastern. Forms and procedures you may need are available on our Web site at www.wellcarepffs.com/provider.

Important fax numbers:

- Provider payment dispute resolution fax: 1-866-473-9122
- Provider appeal for medical necessity and/or benefits fax: 1-866-201-0657
- Provider advance determination fax: 1-813-464-8764
- Provider Pharmacy (Coverage Determination form) fax: 1-877-277-1809
- Provider Pharmacy (Appeals) fax: 1-813-262-2907

SERVICE AREA | Section 2

Though most of WellCare PFFS plans are non-network, in certain markets we offer network plans. In 2009, WellCare PFFS introduced primary care physician (PCP) only network plans in some counties in Arkansas and California. In all other markets there is not a defined network for WellCare PFFS medical services.

Non-network PFFS plans do not limit members to a service area, state or region to obtain their medical care. Both network and non-network members may see any participating provider in our network or any other provider of their choice if the provider accepts Medicare and *WellCare PFFS Terms and Conditions of Payment*.

WellCare PFFS plans, both network and non-network, do not require the designation of a primary care physician (PCP).

Providers may obtain a copy of *WellCare PFFS Terms and Conditions of Payment* by visiting our Web site at www.wellcarepffs.com/provider/terms or by calling our Provider Service Center at 1-866-235-2770 (TTY/TDD: 1-866-239-6265) Monday–Sunday, 7am to 2am Eastern.

Please note that although network members can receive care from either a network or non-network provider, these members may have reduced cost-sharing when visiting a network PCP provider.

There are defined ancillary networks for WellCare PFFS plans, which offer non-Medicare-covered services, including hearing, vision, dental and fitness benefits. Benefits and directories for these networks can be found at www.wellcarepffs.com.

QUESTIONS & ANSWERS ABOUT WELLCARE PRIVATE FEE-For-SERVICE | Section 3

1. What is a Private Fee-for-Service (PFFS) plan?

A Private Fee-for-Service (PFFS) plan is a Medicare Advantage (MA) health plan offered by a state-licensed risk-bearing entity that has a yearly contract with the Centers for Medicare & Medicaid Services (CMS) to provide beneficiaries with all their Medicare benefits, plus any additional benefits the company decides to provide.

2. How do WellCare PFFS plans work and how do members obtain care?

WellCare PFFS plans allow members to use any provider—such as a physician, health professional, hospital or other Medicare provider in the United States—who agrees to treat the member after having the opportunity to review a plan's terms and conditions of payment (www.wellcarepffs.com/provider/terms), as long as the provider is eligible to provide health care services under Medicare Part A and Part B (also known as 'Original Medicare') or eligible to be paid by WellCare PFFS for ancillary benefits—non-Medicare-covered hearing, vision, dental and fitness.

A provider must agree to accept *WellCare PFFS Terms and Conditions of Payment* prior to providing health care services to members, with the exception of emergencies.

Please note that although network members can receive care from either a network or non-network provider, these members may have reduced cost-sharing when visiting a network PCP provider.

3. What is the difference between an HMO and a WellCare PFFS plan?

With a WellCare PFFS plan, members have the freedom to see any Medicare-eligible doctor or hospital who accepts *WellCare PFFS Terms and Conditions of Payment*, as long as the provider is eligible to provide health

care services under Medicare Part A and Part B (also known as ‘Original Medicare’) or eligible to be paid by WellCare PFFS for ancillary benefits—non-Medicare-covered hearing, vision, dental and fitness.

Reimbursement is based on published Medicare rates. Medicare Local Medical Review Policies will apply. To review WellCare PFFS’ specific payment rates, guidelines and methodologies, visit www.wellcarepffs.com/provider/claiminformation and click on the *WellCare Proxy Payment Grid*.

4. What if a provider chooses not to accept a WellCare PFFS plan?

If the provider DOES NOT wish to accept *WellCare PFFS Terms and Conditions of Payment*, then he/she should not furnish services to a WellCare PFFS member, except for emergency services. If he/she nonetheless does furnish non-emergency services, he/she will be subject to these terms and conditions whether he/she wishes to agree to them or not. Providers furnishing emergency services will be treated as non-contract providers and paid at the payment amounts they would have received under Original Medicare.

5. Who can join a PFFS plan?

Beneficiaries can join a PFFS plan if:

- They have both Medicare Part A (hospital insurance) and Part B (medical insurance).
- They do not have End-Stage Renal Disease (permanent kidney failure treated by dialysis or a transplant, sometimes called ESRD), unless transferring from another WellCare Medicare Advantage plan.
- They live in the service area of the PFFS plan.

6. What is a dual-eligible member?

Medicare/Medicaid dual-eligible members are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.

Providers who participate with Medicare and Medicaid cannot balance-bill WellCare’s PFFS dual-eligible members for any Medicare covered services. If you have questions or concerns regarding coordination of payment, please visit our Web site under the “Our Plans” option found at www.wellcarepffs.com.

7. How are sales agents selected to sell WellCare PFFS products? What training do they receive?

Sales agents are required to hold an active state license and be in good standing with the state insurance department in the states they sell. They must carry errors and omissions insurance and successfully pass criminal background checks. All contracted sales agents are also required to attend WellCare compliance and product training.

ENROLLMENT AND ELIGIBILITY | Section 4

Beneficiaries can join a PFFS plan if:

- They have both Medicare Part A (hospital insurance) and Part B (medical insurance).
- They do not have End-Stage Renal Disease (permanent kidney failure treated by dialysis or a transplant, sometimes called ESRD), unless transferring from another WellCare Medicare Advantage plan.
- They live in the service area of the PFFS plan.

Current and prospective members may contact WellCare’s Customer Service department for questions related to WellCare PFFS plans at 1-866-238-9898 (TTY/TDD: 1-866-239-6265), seven days a week, 8am to 2am Eastern.

Current and prospective members should also contact WellCare Customer Service for questions related to the Medicare Part D Prescription Drug program offered under WellCare’s PFFS plan products.

Eligibility Verification | Section 4A

A member's eligibility status can change at any time. Therefore, all providers should request a copy of each member's identification card (ID), along with additional proof of identification such as a photo ID. These should become a part of the patient's medical record.

The provider may further validate eligibility by calling our Provider Service Center at 1-866-235-2770 (TTY/TDD: 1-866-239-6265) Monday–Sunday, 7am to 2am Eastern. Registered Web site users may visit www.wellcarepffs.com/provider/eligibilityandbenefits to validate eligibility via our provider portal.

Member ID cards usually include the PFFS denotation, but specifically, you can identify a WellCare PFFS member by looking at his or her member ID number. The ID number for WellCare PFFS members should begin with the letter "F". If it contains only numerals, and no "F" prefix, then he or she is not a WellCare PFFS member and could be with one of WellCare's other plans.

Identification Card | Section 4B

Member identification cards are intended to identify plan members and facilitate their interactions with physicians and other health care providers. Information found on the member identification card may include the member's name, identification number, plan and product name, co-payment information, health plan contact information and claims filing address. Possession of the member identification card does not prove eligibility or coverage. The physician or provider is responsible for ascertaining the current eligibility of the card holder (see Eligibility Verification | Section 4A). CMS requires that enrollees become effective the first day of the month following receipt of their application. This could result in our member having an appointment prior to their receipt of a WellCare PFFS ID card.

To see a sample of our WellCare PFFS ID card visit www.wellcarepffs.com/provider/eligibilityandbenefits and click on "... 2009 member ID cards."

Plan Benefits | Section 4C

When members are enrolled in PFFS plans, they are entitled to all medically necessary health care services that are covered by Medicare. Additionally, some PFFS plan products, including WellCare, may have benefits that Medicare does not cover.

Plans vary by state and county. You can review specific benefits for members by visiting www.wellcarepffs.com/ourplans/ourplans, selecting the state and then county under which the member is covered.

You may also call our Provider Service Center at 1-866-235-2770 (TTY/TDD: 1-866-239-6265) Monday–Sunday, 7am to 2am Eastern to obtain more information about covered benefits, plan payment rates and member cost-sharing amounts under WellCare PFFS. Be sure to have the member's ID number when you call.



Non-discrimination in Delivery of Health Services | Section 4D

WellCare’s PFFS plan prohibits its providers from discriminating against patients. Physicians will not discriminate or differentiate in the treatment of any WellCare PFFS member because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, source of payment or health status.

Providers need to ensure all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. WellCare’s Quality Improvement Committee will investigate any member comments or complaints about cultural sensitivity.

All companies and agencies that work with Medicare must obey the law. Members cannot be treated differently because of race, color, national origin, disability, age, religion or sex under certain conditions.

Also, member rights to health information privacy are protected. Members may contact the Department of Health and Human Services, Office for Civil Rights for their state, or call toll-free 1-800-368-1019 (TTY/TDD: 1-800-537-7697). Members may also visit www.hhs.gov/ocr on the Web for more information.

Member Rights Under Medicare | Section 4E

Medicare members have the right to:

- Obtain information and access to records that pertain to them in a timely manner.
- Receive emergency room and/or urgently needed care services.
- See doctors and specialists (including women’s health specialists), and go to Medicare-certified hospitals.
- Participate in treatment decisions.
- Know treatment choices.
- Get information in a culturally competent manner in certain circumstances (for example, get information from Medicare, and its providers and contractors, in languages other than English).
- File complaints, grievances and/or appeals (covered in Section 7).
- Non-discrimination.
- Have all personal and health information kept private.
- Be provided with information on benefits, limitations and applicable exclusions.
- Exercise advance directives in the event the member is unable to express his or her wishes.
- Refuse treatment and be advised of the consequences of that decision.

Advance Directives | Section 4F

Members have the right to control decisions relating to their medical care. This includes the decision to have medical or surgical procedures halted or withheld.

The law provides that each plan member (18 years of age or older and of sound mind) should receive information concerning this provision, and have the opportunity to sign an Advance Directive Acknowledgement Form to make his or her medical preferences/decisions known in advance. This allows members to designate another person who will make medical decisions on the member’s behalf, should the member become unable to do so. Said forms should be available in providers’ offices. Each state has legal guidelines for advance directives.

Additionally, WellCare's PFFS plan encourages all members to address their wishes with their physicians. Within the medical record, providers must document whether or not the member has executed an advance directive. The provision of care cannot be conditioned, and a member may not be otherwise discriminated against based on whether or not the member has executed an advance directive.

WellCare's PFFS plan will provide written information to all members upon enrollment that explains their right under state and federal law to make decisions about their medical care, including their right to refuse care and the right to establish advance directives. This written information includes, but is not limited to an explanation of advance directives, living wills and health care agents. Also included is an overview of the state and federal laws governing patient self-determination.

Member's Participation in Decision Making | Section 4G

When WellCare PFFS members go to a doctor or hospital, they must inform the provider that they are enrolled in a WellCare PFFS plan. If there is a question whether WellCare's PFFS plan will pay for a service, including inpatient hospital services, members have the right under the law to have a written/binding advance coverage determination for the service. Members can contact WellCare's PFFS plan and advise that they want a decision in writing regarding whether or not the service will be paid for by the plan. Evidence of Coverage documents should also be verified in cases where a member is unsure of coverage.

On a voluntary basis, members will be invited to use the services of care coordinators. These care coordinators are highly trained specialists in treatment options, including the option of no treatment.

Additionally, the advance directive package made available to all WellCare PFFS members provides an opportunity for members to specify their wishes for care. Translation services are available to meet members' language needs.

Member Case Management | Section 4H

Providers are encouraged to inform WellCare's PFFS plan of members who may benefit from a team effort between the plan and the provider to ensure that needed care is administered. Members would be considered for case management depending on their diagnosis and certain chronic conditions.

Authorization and Review Rules Notification | Section 4I

No prior authorization, prior notification or referral is required as a condition of coverage when medically necessary, plan-covered services are furnished to a member.

Advance Coverage Determination | Section 4J

Providers may choose to obtain a written advance coverage determination (also known as an organization determination) from WellCare PFFS before furnishing a service in order to confirm whether the service is medically necessary and will be covered by WellCare PFFS. To obtain an advance coverage determination, call us at 1-866-235-2770 or fill out the form located at www.wellcarepffs.com/provider/forms and fax it to 1-813-464-8764. WellCare PFFS will make a decision and notify you within 14 days of receiving the request, with a possible 14-day extension either due to the member's request or WellCare PFFS justification that the delay is in the

member's best interest. In cases where you believe that waiting for a decision under this time frame could place the member's life, health or ability to regain maximum function in serious jeopardy, you can request an expedited determination. To obtain an expedited determination, call us at 1-866-235-2770 or fill out the form located at www.wellcarepffs.com/provider/forms and fax it to 1-813-464-8764. WellCare PFFS will notify you of the decision within 72 hours. These forms are also located in the Forms Section in the back of this guide.

In the absence of an advance coverage determination, WellCare PFFS can retroactively deny payment for a service furnished to a member if it is determined that the service was not covered or was not medically necessary. However, providers have the right to dispute our decision by exercising member appeals rights.

Provider Advice to Members Regarding Health Care Options | Section 4K

Medicare Advantage (MA) organizations are prohibited from interfering with a health care professional who is acting in the lawful scope of his or her practice on matters of advising or advocating on behalf of a member enrolled in an MA plan with regard to:

- The patient's health status, medical care or treatment options, including adequate information regarding all relevant treatment options
- The risks, benefits and outcomes of treatment or non-treatment
- The opportunity to refuse treatment or preferred future treatment decisions

Health care professionals must provide information regarding treatment options, including the option of no treatment, in a culturally competent manner. They must ensure that members have access to communicate with the health care system regarding treatment options.

PROVIDER INFORMATION | Section 5

How to Participate | Section 5A

Provider questions and answers on how to participate:

1. What qualifications must a health care provider have in order to be eligible to furnish services to Medicare beneficiaries who are enrolled in a WellCare PFFS plan?

A member of WellCare's PFFS plan can obtain covered health care services from any Medicare-eligible doctor or hospital anywhere in the United States who is willing to provide care and accept WellCare PFFS Terms and Conditions of Payment and meet the following:

- Have a National Provider Identifier in order to submit electronic transactions to WellCare PFFS, in accordance with HIPAA requirements.
- Submit non-electronic transactions using the standard CMS-1500 or CMS-1450 (UB-04), paying special attention to your National Provider Identifier (NPI), the member's name exactly as indicated on their ID card and the member's ID number.
- Furnish services to a WellCare PFFS member within the scope of your licensure or certification.
- Provide only services that are covered by our plan and that are medically necessary by Medicare definitions.
- Meet applicable Medicare certification requirements (e.g., if you are an institutional provider such as a hospital or skilled nursing facility).

- Not have opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services.
- Not be on the HHS Office of Inspectors General excluded and sanctioned provider lists.
- Not be a federal health care provider, such as a Veterans' Administration provider, except when providing emergency care.
- Comply with all applicable Medicare and other applicable federal health care program laws, regulations and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members.
- Agree to cooperate with WellCare PFFS to resolve any member grievance involving the provider within the time frame required under federal law.
- For providers who are hospitals, home health agencies, skilled nursing facilities or comprehensive outpatient rehabilitation facilities, provide applicable beneficiary appeals notices.
- Not charge the member in excess of cost-sharing under any condition, including in the event of plan bankruptcy.
- Agree to bill WellCare PFFS dental, vision and hearing vendors for non-Medicare-covered services that are covered by WellCare PFFS. For information on how to contact these vendors, please see the member's dental/hearing/vision ID card or the *WellCare PFFS Quick Reference Contact Guide*.

Once these conditions are met, a physician or provider may provide covered services to a WellCare PFFS member. The physician or provider will be reimbursed in accordance with the *WellCare Proxy Payment Grid* found at www.wellcarepffs.com/provider/claiminformation.

2. What does it mean for a provider to be deemed under WellCare's PFFS Plan?

A provider is considered by law to be deemed to have a contract with WellCare PFFS when all of the following three criteria are met:

1. The provider is aware, in advance of furnishing health care services, that the patient is a member of WellCare PFFS.
 - a. All of our members receive a member ID card that includes the WellCare logo and clearly identifies them as PFFS members. Also, you can identify a WellCare PFFS member by looking at his or her member ID number. The ID number for WellCare PFFS members should begin with the letter "F". If it contains only numerals, and no "F" prefix, then it is not a WellCare PFFS member and could be with one of WellCare's other plans.
 - b. The provider may further validate eligibility by calling our Provider Service Center at 1-866-235-2770 (TTY/TDD: 1-866-239-6265) Monday–Sunday, 7am to 2am Eastern. Registered Web site users may visit www.wellcarepffs.com/provider/eligibilityandbenefits to validate eligibility via our provider portal.
2. The provider either has a copy of, or has reasonable access to, our terms and conditions of payment. (The terms and conditions are available on our Web site at www.wellcarepffs.com/provider/terms.)
3. The provider furnishes covered services to a WellCare PFFS member.

If all of these conditions are met, the provider is deemed to have agreed to *WellCare PFFS Terms and Conditions of Payment* for that member specific to that visit. Note: You, the provider, can decide whether or not to accept *WellCare PFFS Terms and Conditions of Payment* each time you see a WellCare PFFS member.

A decision to treat one plan member does not obligate you to treat other WellCare PFFS members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

For example: If a WellCare PFFS member shows you an enrollment card identifying him/her as a member of WellCare PFFS, and you provide services to that member, you will be considered a deemed provider. Therefore, it is your responsibility to obtain and review the terms and conditions of payment prior to providing services, except in the case of emergency services.

If you DO NOT wish to accept *WellCare PFFS Terms and Conditions of Payment*, then you should not furnish services to a WellCare PFFS member, except for emergency services. If you nonetheless do furnish non-emergency services, you will be subject to these terms and conditions whether you wish to agree to them or not. Providers furnishing emergency services will be treated as non-contract providers and paid at the payment amounts they would have received under Original Medicare.

3. What is a non-contracted provider?

If a provider furnishes services to a WellCare PFFS member but the deeming requirements are not met, the provider becomes a non-contracted provider. For example, a provider cannot become deemed in circumstances where the provider does not know in advance of furnishing services that a patient is a member of a WellCare PFFS plan. This could occur in an emergency where a provider cannot communicate with the patient before furnishing care, or in certain situations where the member does not inform the provider of their enrollment in a WellCare PFFS plan. As a further example, a provider cannot become a deemed provider if the provider has not received or does not have reasonable access to the *WellCare PFFS Terms and Conditions of Payment* prior to furnishing services to the WellCare PFFS member.

4. What happens if a provider furnishes services to a WellCare PFFS member, but the deeming conditions have not been met?

If a provider furnishes services to a WellCare PFFS member and the conditions of deeming have not been met, then the provider is considered a non-contracted provider. It is important to note that a provider can choose whether or not to furnish services to a member of a WellCare PFFS plan. However, if a provider furnishes services, the provider cannot choose whether he/she is classified as a deemed or a non-contracted provider. If a provider is aware in advance of furnishing services that a person is a member of a WellCare PFFS plan, and the provider has access to the *WellCare PFFS Terms and Conditions of Payment*, the provider is automatically a deemed provider. A provider is only classified as a non-contracted provider if he/she furnishes services to a WellCare PFFS member and the deeming conditions have not been met.

5. Is a Medicare provider who accepts assignment required to accept a WellCare PFFS member for care?

No, you are not required to accept members. If you DO NOT wish to accept *WellCare PFFS Terms and Conditions of Payment*, then you should not furnish services to a WellCare PFFS member, except for emergency services. If you nonetheless do furnish non-emergency services, you will be subject to these terms and conditions whether you wish to agree to them or not. Providers furnishing emergency services will be treated as non-contract providers and paid at the payment amounts they would have received under Original Medicare.



2009 WellCare Private Fee-for-Service (PFFS) Terms and Conditions of Payment | Section 5B

The *2009 WellCare Private Fee-for-Service (PFFS) Terms and Conditions of Payment* can be found at www.wellcarepffs.com/provider/terms or by contacting our Provider Service Center at 1-866-235-2770 (TTY/TDD: 1-866-239-6265) Monday–Sunday, 7am to 2am Eastern.

Please review the terms and conditions before agreeing to furnish services to a WellCare PFFS member, except for emergency services.

Member Benefits and Cost-Sharing

Payment of cost-sharing amounts is the responsibility of the member. Providers should collect the applicable cost-sharing from the member at the time of the service when possible. You can only collect from the member the appropriate WellCare PFFS cost-sharing amounts described in these terms and conditions. After collecting cost-sharing from the member, the provider should bill WellCare PFFS for covered services. Section 6 provides instructions on how to submit claims to us. If a member is a dual-eligible Medicare beneficiary (that is, the member is eligible for Medicare and a state Medicaid program) that the state holds harmless for Medicare cost-sharing, then the provider cannot collect any cost-sharing from the member at the time of service. Instead, the provider may only look to the state Medicaid agency to collect the Medicaid allowable cost-sharing amount(s).

To view a complete list of covered services and member cost-sharing amounts under WellCare PFFS, go to www.wellcarepffs.com/ourplans/ourplans. You may call us at 1-866-235-2770 to obtain more information about covered benefits, plan payment rates and member cost-sharing amounts under WellCare PFFS. Be sure to have the member's ID number when you call.

WellCare PFFS follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by WellCare PFFS, unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 4J. WellCare PFFS does not require members or providers to obtain prior authorization, prior notification or referrals from the plan as a condition of coverage. Under prior authorization, a plan requires beneficiaries or providers to seek authorization from the plan prior to obtaining services. There is no such requirement for WellCare PFFS members.

Note: Medicare supplemental policies, commonly referred to as Medigap plans, cannot cover cost-sharing amounts for Medicare Advantage plans, including PFFS plans. All cost-sharing is the member's responsibility.

Balance Billing of Members

A provider may collect only applicable plan cost-sharing amounts from WellCare PFFS members and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish plan-covered services to WellCare PFFS members.

Hold Harmless Requirements

In no event, including, but not limited to, nonpayment by WellCare PFFS, insolvency of WellCare PFFS, and/or breach of these terms and conditions, shall a deemed provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or persons acting on their behalf for plan-covered services provided under these terms and conditions. This provision shall not prohibit the collection of any applicable coinsurance, co-payments or deductibles billed in accordance with the terms of the member's benefit plan.

If any payment amount is mistakenly or erroneously collected from a member, the provider must make a refund of that amount to the member.

Providing Members with Notice of Their Appeals Rights—Requirements for Hospitals, SNFs, CORFs and HHAs

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare (IM), including the time frames for delivery. For copies of the notice and additional information regarding this requirement, go to: www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

Skilled nursing facilities, comprehensive outpatient rehabilitation facilities and home health agencies must notify Medicare beneficiaries about their right to appeal a termination of services decision by complying with the requirements for providing Notice of Medicare Non-Coverage (NOMNC), including the time frames for delivery. For copies of the notice and the notice instructions, go to: www.cms.hhs.gov/MMCAG/Downloads/NOMNCForm.pdf and www.cms.hhs.gov/MMCAG/Downloads/NOMNCInstructions.pdf. In addition, the provider should send a copy of any NOMNC issued to P.O. Box 31490, Tampa, FL 33631-3490 or fax to 1-813-464-8764.

WellCare PFFS will provide members with a detailed explanation if a member notifies the Quality Improvement Organization (QIO) that the member wishes to appeal a decision regarding a hospital discharge or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services within the time frames specified by law.

Medical Records | Section 5C

Providers shall maintain timely and accurate medical, financial and administrative records related to services they render to WellCare PFFS members. Unless a longer time period is required by applicable statutes or regulations, the provider shall maintain such records for at least 10 years from the date of service. Deemed providers must provide WellCare, the Department of Health and Human Services, the Comptroller General, or their designees access to any books, contracts, medical records, patient care documentation and other records maintained by the provider pertaining to services rendered to Medicare beneficiaries enrolled in a Medicare Advantage plan, consistent with federal and state privacy laws. Such records may be used for activities in the following situations: Centers for Medicare & Medicaid Services and WellCare audits of risk adjustment data; WellCare determinations of whether services are covered under the plan are reasonable and medically necessary, and whether the plan was billed correctly for the service; and in order to make advance coverage determinations. WellCare PFFS will not use medical record reviews to create artificial barriers that would delay payments to providers. Both voluntary and mandatory provision of medical records must be consistent with HIPAA privacy law requirements.

Confidentiality of Member Information and Release of Records | Section 5D

Confidentiality and accuracy of a WellCare PFFS member's medical record must be safeguarded. Information from or copies of a member's medical record may only be released to authorized parties. Physicians and all other providers must ensure that unauthorized parties cannot gain access to or alter a member's medical record. Records may only be released in accordance with state laws, subpoenas, and court orders. WellCare PFFS members' access to the information that pertains to them must be ensured.

WellCare's PFFS plan has adopted and implemented a comprehensive privacy policy that supports the requirements under HIPAA. WellCare's PFFS plan complies with the HIPAA Privacy Regulations in regard to disclosing or sharing Protected Health Information outside its organization. WellCare's PFFS plan requires a current HIPAA compliant authorization, signed by the policyholder, before disclosing such information.

Additionally, the member will have timely access to records and information within the specified time frames included in HIPAA and as applicable to Medicare Advantage policies. All consultations or discussions involving the member or his/her case should be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the HIPAA Privacy and Security regulations. All qualifying physician practice personnel should be trained on HIPAA Privacy and Security regulations. The physician practice should ensure there is: (i) a Privacy Officer on staff; (ii) a policy and procedure in place for confidentiality of members' Protected Health Information; and (iii) that the practice is following those procedures and/or obtaining appropriate authorization from members to release Protected Health Information where required by applicable state and federal law. When an individual enrolls in a plan, federal law permits the health care provider to release members' medical records to WellCare's PFFS plan, other members of the provider network, agencies conducting regulatory or accreditation reviews, and business associates.

WellCare, physicians and all other providers must abide by all federal and state laws with regard to confidentiality and disclosure of mental health records, medical records, and other health and member information. Additionally, WellCare PFFS members will have timely access to records and information within the specified time frames included in HIPAA and as applicable to Medicare Advantage policies. The following information applies to medical records for Medicare members:

1. A member's medical record must contain the quality, quantity, appropriateness and timeliness of services performed.
2. All entries in the medical record must be signed. All entries must include the name and profession of the practitioner rendering services, for example, RN, MD, DO, including the signature or initials of the practitioner.
3. All entries in the medical record must be dated and recorded in a timely manner.
4. Medical records must be legible to readers and reviewing parties. They must be maintained in an orderly and detailed manner.
5. The following personal and biographical data must be included in the medical record: name, member ID number, address, telephone number, date of birth, sex, and both emergency contact and legal guardianship contact information. In addition, for translation requirements, the member's language preference should be noted. The medical record should also include: the member's marital status, the name of his or her spouse, the name and address of any next of kin and any employer, insurance information, and family and medical history.
6. Medication allergies or "no known allergies" and data reflecting negative reactions to drugs, must be prominently noted.
7. Medical records that have been obtained from any previous provider and are easily accessible should be included. These may include past medical history, data from past physical examinations, necessary test results and possible risk factors for the member relevant to treatment, and are used to assess the periodicity schedule and maintain the continuity of care.
8. An immunization record should be maintained in the record as appropriate.

9. A listing of all the medications the member is taking should be maintained in the record. This includes prescribed medications with the frequency of dosages and the dates of both the initial prescription and its refill(s). Also included should be a list of any sample medications dispensed to the member.
10. Intended to provide continuity of care, a problem list detailing past and current diagnoses and procedures. This includes a summary of significant surgical procedures, past and present diagnoses or problems, past and present medication reactions, etc. Evidence that the member was asked about Advance Directives and documentation of their acceptance or refusal. See Section 4J for further information on Advance Directives.
11. All records must reflect the primary language spoken by the member, along with any translation/communication needs of the member.

PAYMENT AND CLAIMS INFORMATION | Section 6

WellCare PFFS reimburses deemed providers at the amount they would have received as participating or non-participating physicians, as applicable, under Original Medicare, minus any member required cost-sharing, for all medically necessary services covered by Medicare. We will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, then we will pay interest on the claim according to Medicare guidelines. More information on prompt payment rules follow in 6A. Payment to providers for which Medicare does not have a publicly published rate will be based on the estimated Medicare amount. To review WellCare PFFS' specific payment rates, guidelines and methodologies for non-ancillary services, visit www.wellcarepffs.com/provider/claiminformation and click on the *WellCare Proxy Payment Grid*.

Services covered under WellCare PFFS that are not covered under Original Medicare (ancillary services such as dental, vision and fitness) are reimbursed using WellCare PFFS vendors' fee schedules. Please call us at 1-866-235-2770 to receive information on these fee schedules.

Deemed providers furnishing such services must accept the fee schedule amount, minus applicable member cost-sharing, as payment in full.

Submission of Claims | Section 6A

You must submit a claim to WellCare PFFS for an Original Medicare-covered service within the same time frame you would have to submit under Original Medicare, which is within 15–27 months from the date of service. (For services received between October 1, 2007, and September 30, 2008, claims must be submitted by December 31, 2009. For services received between October 1, 2008, and September 30, 2009, claims must be submitted by December 31, 2010. For services received between October 1, 2009, and December 31, 2009, claims must be submitted by March 31, 2011.) Failure to be timely with claim submissions may result in non-payment. The criteria for Original Medicare submission of claims can be found in section 70 of Chapter 1 of the Medicare Claims Processing Manual located at www.cms.hhs.gov/manuals/downloads/clm104c01.pdf.

Prompt Payment—WellCare PFFS will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, WellCare PFFS will pay interest on the claim according to Medicare guidelines. A clean claim includes the minimum information necessary to adjudicate a claim, not to exceed the information required by Original Medicare. WellCare PFFS will process all non-clean claims and notify providers of the determination within 60 days of receiving such claims.

Submit claims using the standard CMS-1500, CMS-1450 (UB-04) or the appropriate electronic filing format. We encourage you to submit claims electronically. These claims should process faster and with minimal chance of error. Of course, accurate claims data are crucial.

Use the same coding rules and billing guidelines as Original Medicare, including Medicare CPT codes, HCPCS codes and defined modifiers. Bill diagnosis codes to the highest level of specificity.

Pay special attention to accuracy of the following on your claims:

- National Provider Identifier (NPI).
- The member's ID number.
- The member's name exactly as indicated on his or her ID card.
- The provider and/or practice entity names and Tax Identification Number (TIN) that match those on the W-9.
- Date(s) of service.
- For providers who are paid based upon interim rates, include with your claim a copy of your current interim rate letter.
- For providers rendering laboratory services requiring CLIA waiver/certificate, please include your CLIA number on each submission.

Coordination of Benefits—All Medicare secondary payer rules apply. These rules can be found in the Medicare Secondary Payer Manual located at www.cms.hhs.gov/Manuals/IOM/list.asp. Providers should identify primary coverage and provide information to WellCare PFFS at the time of billing.

Where to submit a claim:

For electronic claim submission, WellCare PFFS EDI Payer ID number is 77072. (In some markets, WellCare has multiple product lines and it is important to use this number for PFFS claims.)

If you need technical assistance or would like to register for electronic claim submission, contact: Emdeon Business Services between 8am and 8pm Eastern at 1-800-845-6592, or register online at <http://emdeon.com>.

For paper claim submission:

Medicare-Covered Claims:

WellCare Health Plans, Inc.
P.O. Box 4438
Scranton, PA 18505

Non-Medicare-Covered Claims:

Dental	Vision	Hearing
WellCare Health Plans, Inc. P.O. Box 4438 Scranton, PA 18505	Advantica EyeCare P.O. Box 6546 Ellicott City, MD 21042	HearUSA Hearing Care Network P.O. Box 220807 West Palm Beach, FL 33422

For billing questions, contact our Provider Service Center at 1-866-235-2770.

Billing Original Medicare for WellCare PFFS claims

Claims for services provided to WellCare PFFS members will **not** be paid by Original Medicare and will be rejected if sent to a carrier or intermediary. Providers must bill WellCare PFFS.

Provider Claim Payment Dispute Resolution Process | Section 6B

If you believe that the payment amount you received for a service is less than the amount indicated in our terms and conditions of payment, you have the right to dispute the payment amount by following our dispute resolution process.

To file a payment dispute with WellCare PFFS, send the “Provider Claim Payment Resolution Process Form,” a copy of the claim being disputed and all appropriate documentation that supports your payment dispute (e.g., the remit and any information that Original Medicare would pay differently for the service on the claim) by mail or fax to:

WellCare Health Plans, Inc.
P.O. Box 4438
Scranton, PA 18505

Fax: 1-866-473-9122

A copy of our *Provider Claim Payment Resolution Form* is available at www.wellcarepffs.com/provider/forms or in the Forms Section in the back of this guide. Claims must be disputed within 120 days from the date payment is initially received by the provider.

We will review your dispute and respond to you within 30 days from the time the provider payment dispute is first received by WellCare PFFS. If we agree with your payment dispute, then we will pay you the additional amount with any interest that is due. We will inform you in writing if your payment dispute is denied.

After completing WellCare PFFS payment dispute resolution process, if you believe that we have reached an incorrect decision regarding your payment dispute, you may file a request for review of this determination with an independent entity contracted by CMS. To file a request for review of a payment dispute with the independent entity, you may contact the entity directly at the contact options listed below.

Deemed and non-contracted providers should request an independent Payment Dispute Decision (PDD) from First Coast Service Options, Inc., (FCSO) within 180 days of the written notice from WellCare PFFS about the initial claims dispute. The request must be in writing and should be made on a standard PDD form available at FCSO’s Web site, www.fcso.com. FCSO has established the following options for receipt of payment dispute decision requests:

1. **E-mail.** If the submission and associated documents do not contain any personally identifiable health information (PHI) or any PHI has been redacted, the payment dispute decision request can be submitted via e-mail to a dedicated box at IREPFFS@FCSO.com. Otherwise, FCSO can receive payment dispute decision requests (including associated documents such as claims forms that may contain PHI) via fax or mail.



2. **Fax.** 1-904-361-0551. This fax number has been established to receive electronic requests for payment dispute decisions.
3. **Mail.** Providers can mail hard copy requests for payment dispute adjudication to the following address:

First Coast Service Options, Inc.
PFFS Payment Disputes
P.O. Box 44017
Jacksonville, FL 32231-4017

Providers with questions regarding the adjudication process or individual disputes being reviewed by the independent review entity (IRE) can contact FCSO at 1-904-791-6430.

The IRE will issue a decision within 60 days of receiving a provider payment dispute unless granted an exception by the IRE. When the IRE renders a decision on a case it notifies all parties of its decision. The IRE considers the case closed when it notifies all parties of the decision. However, both parties have the right to request a debrief.

Provider Appeal for Medical Necessity and/or Benefits Process | Section 6C

A provider has 60 days from the date of the initial determination to submit a medical necessity and/or benefit appeal.

- The Provider PFFS Appeal Form, all additional, appropriate appeal forms and medical records should be mailed or faxed to:

WellCare Health Plans, Inc.
Attn: PFFS Provider Appeals
P.O. Box 31368
Tampa, FL 33631
Fax: 1-866-201-0657

- Provider appeals will be resolved, in writing, within 60 days of initial receipt of the appeal by WellCare.

A provider may appeal decisions on behalf of a member as an appointed representative, or appeal on his or her own right using the member's appeal process by signing a waiver of liability (promising to hold the member harmless regardless of the outcome). There must be existing potential member liability (e.g., a claim, as opposed to an advance coverage determination, is denied as not a medically necessary or a covered service) in order for a provider to appeal utilizing the member's appeal process. If you appeal on your own right, you agree to abide by the statutes, regulations, standards and guidelines applicable to the Medicare PFFS Member appeals and grievance process. The waiver of liability and the PFFS Appeal form can be found at www.wellcarepffs.com/provider/forms or in the Forms Section in the back of this guide.

APPEALS AND GRIEVANCES | Section 7

Appeals Process | Section 7A

Definitions (Adapted from CMS)

An **appeal** is any procedure that deals with the review of adverse organization determinations for health care services a member believes he or she is entitled to receive.

An **organization determination** is any determination made by a Medicare health plan with respect to any of the following:

- Payment for temporarily out-of-area renal dialysis services, emergency services, post-stabilization care or urgently needed services.
- Payment for any health services furnished by a provider that the member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for or reimbursed by WellCare PFFS.
- WellCare PFFS' refusal to provide or pay for services, in whole or in part, including the type or level of services that the member believes should be furnished or arranged for by WellCare PFFS.
- Discontinuation of a service if the member believes that continuation of the services is medically necessary.
- Failure of WellCare PFFS to approve, furnish, arrange for or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination.

The **parties to an organization determination** include:

- A member (including his or her representative).
- An assignee of the member (i.e., a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service).
- The legal representative of a deceased member's estate.
- Any other provider or entity (other than the Medicare health plan) determined to have an appealable interest in the proceeding.

Any of these parties can request an organization (or coverage) determination, with the exception that only the member, member's representative or a physician can request an expedited organization determination that does not involve a request for payment of services.

A **reconsideration** is the first step in the appeal process after an adverse organization determination.

Appeal Process

If WellCare PFFS denies coverage or payment for health care services that the member, an assignee of a member, a legal representative of a deceased member's estate or any other provider or entity (other than the Medicare health plan) determined to have an appealable interest in the proceeding, thinks should be covered, he or she has the right to a reconsideration.

A party may request a reconsideration by filing a signed written request with WellCare PFFS. There are three types of reconsideration—expedited pre-service, standard pre-service and retrospective.

The request must be filed within 60 calendar days from the date of the notice of the action or denial. If the request is submitted after 60 calendar days have elapsed from the date of the notice of the action or denial, then good cause must be shown in order for WellCare to accept the late request. Examples of good causes include, but are not limited to:

- The adverse organization determination notice was not received or received late.
- Seriously illness prevented a timely appeal.
- There was an immediate family member illness or death.
- An accident caused important records to be destroyed.
- Documentation was difficult to locate within the time limits.
- Incorrect or incomplete information concerning the reconsideration process was provided.
- There was a lacked capacity to understand the time frame for filing a request for reconsideration.

WellCare PFFS must make a determination on a request for appeal and notify the appropriate party within the following time frames:

- Expedited pre-service reconsideration: 72 hours
- Standard pre-service reconsideration: 30 calendar days
- Retrospective reconsideration: 60 calendar days

A provider who has questions regarding the filing or status of an appeal should contact the WellCare PFFS Provider Service Center at 1-866-235-2770 (TTY/TDD: 1-866-239-6265) Monday–Sunday, 7am to 2am Eastern. The Provider Service Center will coordinate with the Appeals department as appropriate.

Non-Contracted Provider Appeals

A non-contracted provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the provider completes a waiver of liability statement, which provides that the provider will not bill the enrollee regardless of the outcome of the appeal. This form can be found on our Web site at www.wellcarepffs.com/provider or in the Forms section at back of this guide.

Physicians and suppliers who have executed a waiver of beneficiary liability are not required to complete the CMS-1696, Appointment of Representative, form. The physician or supplier is not representing the beneficiary, and thus, does not need a written appointment of representation.

When a non-contracted provider files a request for reconsideration of a denied claim but the provider does not submit the waiver of liability documentation, WellCare PFFS will make a reasonable effort to secure the necessary waiver of liability form. WellCare PFFS cannot undertake a review until or unless the form is received. The time frame for acting on a reconsideration request commences when the properly executed waiver of liability form is received. If WellCare PFFS does not receive the form by the conclusion of the appeal time frame, WellCare PFFS will forward the case to the independent review entity with a request for dismissal.

Standard Pre-Service Reconsideration

A party may request a standard reconsideration by filing a signed, written request with WellCare PFFS. Except in the case of an extension of the filing time frame, a party must file the request for reconsideration within 60 calendar days from the date of the notice of the organization determination.

WellCare PFFS will make a determination and provide notification within 30 calendar days from receipt of the standard pre-service request. One of two determinations will be made:

Affirmation of Denial—Standard Pre-Service Reconsideration

If WellCare PFFS affirms its initial action and/or denial (in whole or in part), it will:

- Submit a written explanation for a final determination with the complete case file to the Independent Review Entity (IRE) contracted by CMS.
- Notify the member of the decision to affirm the denial and that the case has been forwarded to the IRE.

IRE Process

- The IRE must issue a final determination as expeditiously as the member's health or condition requires, but no more than 30 calendar days from receipt of the case.
- Once a final determination has been made, the IRE will notify the member and the plan.
 - If the IRE agrees with WellCare PFFS it will give the member further appeal rights.
 - If the IRE overturns the denial, the IRE notifies the member in writing of the decision.
 - ◊ WellCare PFFS will provide an authorization number within 72 hours (expedited cases) if the member's condition warrants it, but no more than 14 calendar days from receipt of the IRE's determination.

Reversal of Denial—Standard Pre-Service Reconsideration

If WellCare PFFS overturns its initial action and/or denial, it will notify the party in writing within 30 calendar days of receipt of the standard pre-service request.

Expedited Pre-Service Reconsideration

A member or any physician may request that WellCare PFFS expedite a reconsideration, in situations where applying the standard procedure could seriously jeopardize the member's life, health or ability to regain maximum function, including cases in which WellCare PFFS makes a less than fully favorable decision for the member. In light of the short time frame for deciding expedited reconsiderations, a physician does not need to be an authorized representative to request an expedited reconsideration on behalf of the member. A request for payment of a service already provided to a member does not qualify for review as an expedited reconsideration.

A provider may request an expedited reconsideration by contacting the WellCare PFFS Provider Service Center at 1-866-235-2770 (TTY/TDD: 1-866-239-6265) Monday–Sunday, 7am to 2am Eastern, via fax to 1-866-201-0657 or in writing to WellCare's Appeals department at P.O. Box 31368, Tampa, FL 33631-3368

The request must state that it is a request for an expedited reconsideration. In addition, the request must state the reasons why the case should be expedited. In order to meet criteria for expedited review, it must be shown that applying the standard procedure could seriously jeopardize the member's life, health or ability to regain maximum function. WellCare PFFS will make a determination within 72 hours from receipt of the request.



14-Day Extension—Expedited Pre-Service Reconsideration

The determination period of 72 hours may be extended by up to 14 calendar days if the member requests an extension. The time frame may also be extended by up to 14 calendar days if WellCare PFFS justifies a need for additional information and documents that the extension is in the interest of the member. If an extension is granted, the member will be notified verbally and in writing. Such communications will outline the member's further rights should he/she not agree to the extension.

Denial of Expedited Request

If WellCare PFFS denies a request for an expedited reconsideration, then WellCare PFFS will automatically transfer the request to the standard reconsideration process and then make its determination as expeditiously as the member's health condition requires, but no later than 30 calendar days from the date WellCare PFFS received the request for expedited reconsideration.

The plan will notify the member verbally and in writing of the denial and transfer of the request to the standard reconsideration process.

Affirmation of Denial—Expedited Pre-Service Reconsideration

If WellCare PFFS affirms its initial action and/or denial (in whole or in part), it will:

- Submit a written explanation for a final determination with the complete case file to the Independent Review Entity (IRE) contracted by CMS.
- Notify the member of the decision to affirm the denial and that the case has been forwarded to the IRE.

IRE Process

- The IRE has 72 hours from receipt of the case to issue a final determination.
- Once a final determination has been made, the IRE will notify the member and the plan of that determination.
 - If the IRE agrees with WellCare PFFS it will give the member further appeal rights.
 - If the IRE overturns the denial, the IRE notifies the member in writing of the decision.
 - ◊ WellCare PFFS will provide an authorization number within 72 hours of receipt of the IRE's determination, or sooner if the member's health warrants it.

Reversal of Denial—Expedited Pre-Service Reconsideration

If WellCare PFFS overturns its initial action and/or the denial, it will notify the member verbally within 72 hours of receipt of the expedited pre-service request.

Retrospective Reconsideration

If the provider is going to make a retrospective reconsideration request on behalf of the member, the provider and the member must complete an Appointment of Representative form. A copy of the Appointment of Representative form can be found in the Forms section at the back of this guide.

The plan will make a determination and provide notification within 60 calendar days from receipt of the retrospective request.

WellCare PFFS will not take or threaten to take any punitive action against any provider acting on behalf, or in support of, a member requesting an appeal or an expedited appeal.

Member Grievances | Section 7B

What Is a Grievance?

A grievance is any complaint other than one that involves a request for an initial determination or an appeal. Grievances do not involve problems related to approving or paying for Part C medical care or services, problems about having to leave the hospital too soon, and problems about having Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

What Types of Problems Might Lead to Filing a Grievance?

- Problems with the service a member received from Customer Service.
- A member feels he/she is being encouraged to leave (disenroll from) the Plan.
- A member disagrees with our decision not to give a “fast” decision or a “fast” appeal.
- A decision is not rendered within the required time frame.
- Required notices are not supplied.
- A member believes our notices and other written materials are hard to understand.
- Problems with the quality of the medical care or services a member received, including quality of care during a hospital stay.
- Problems with how long a member has to wait on the phone, in the waiting room or in the exam room.
- Problems getting appointments when members need them, or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists or other staff.
- Cleanliness or condition of doctor’s offices, clinics or hospitals.

If a member has one of these types of problems and wants to make a complaint, it is called “filing a grievance.”

Submission of Grievances

A member or provider, acting on behalf of the member, may file a grievance either verbally or in writing within six months of the date of an occurrence that initiated the grievance. A verbal request may be followed by a written request, but the time frame for resolution begins the date the plan receives the verbal filing.

If the member wishes to appoint another person as his or her representative, he/she must complete an Appointment of Representative statement. The member and the person who will be representing the member must sign this statement. A copy of the Appointment of Representative form is located in the Forms Section at the back of this guide and on our Web site at www.wellcarepffs.com/provider/forms.

WellCare PFFS will ensure that punitive action is not taken against a provider who files a grievance on a beneficiary’s behalf or who supports a member’s grievance.

WellCare PFFS must make a determination on a grievance within the following time frames:

- Expedited Request: 24 hours
- Standard Request: 30 calendar days

WellCare PFFS gives members reasonable assistance in completing forms and other procedural steps, including but not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. Members will be provided reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing.

Request for Expedited Grievance Determination

A member or a member's representative may file a request for an expedited grievance determination verbally or in writing. A verbal request can be filed by contacting our Provider Service Center. A written request can be mailed directly to the Grievance Department.

A determination on the expedited request will be made within 24 hours of receipt of the expedited request.

A request for an expedited grievance determination can be made for complaints related to the plan's decisions to:

- Process a request for service or a request to continue service under the standard 72 hour time frame rather than the expedited 14 calendar day time frame
- Process an appeal under the standard process rather than the expedited process
- Invoke a 14 calendar day extension to a request for service or on an appeal

Request for Standard Grievance Determination

A grievance will be investigated, determination made and closure letter sent to the complainant within 30 calendar days of receipt of the standard request.

The closure letter will include the results and date of the grievance resolution, and for decisions not wholly in the member's favor, will include:

- Notice of the right to request a second-level grievance to the plan, that the time limit to file a second-level request is 30 calendar days from the date of the notice, and that he/she may present the case at the second-level Grievance Committee either in person or via teleconference.

Grievances Filed Against a Provider

If a member files a grievance against a provider in reference to the quality of care or service provided, WellCare PFFS will fax and mail a request to the provider for response. The provider is given 10 business days to respond and submit medical records for review. If a provider has not responded within the 10 business days, a second fax and letter is sent giving an additional five business days.

Continued failure to respond may be interpreted that the provider does not disagree with the member's issue. The case is then forwarded to the WellCare Quality Improvement Department for further investigation.

If the provider does respond, the case is referred to a WellCare nurse who reviews the medical records to determine if a possible quality issue exists. If the nurse feels a possible quality issue does exist, the case is referred to a plan Medical Director for review. If he/she determines a quality issue exists, the case is referred to the Quality Improvement Department for further investigation. If no quality issue is identified, the case is entered into WellCare's database for tracking and trending purposes.

14-Day Extension

An extension may be taken to increase the 30 calendar day time frame by up to 14 days if the member requests the extension or if the plan justifies a need for additional information and documents how the delay is in the best interest of the member. When the company extends the deadline, it must immediately notify the member in writing of the reason for the delay.

Quality of Care Issues | Section 7C

Quality of care referrals may be generated by the Appeals, Grievance, Risk Management or Utilization Management Departments, or they may be identified through routine record review.

Any record review identifying possible quality of care issues will be referred to peer review. In the event the peer reviewer/panel feels there is a possible quality of care issue, the physician will be asked, in writing, to provide additional information to address the issue. The response is reviewed and a final determination is rendered.

PHARMACY | Section 8

Overview

The management of outpatient prescription drugs is an integral part of the Medical Management program to improve the health and well-being of our members.

Prescriber and member involvement is critical to the success of the pharmacy program. To help your patient get the most out of his or her pharmacy benefit please be cognizant of the following guidelines when prescribing:

- Follow national standards of care guidelines for treating conditions, i.e., NIH Asthma guideline, JNC VI Hypertension guidelines
- Prescribe drugs from the Formulary
- Prescribe generic drugs when therapeutic equivalent drugs are available
- Evaluate medication profile for appropriateness and duplication of therapy

Formulary

The Formulary is a standardized prescribing reference and clinical guide of prescription drug products selected by WellCare's Pharmaceutical and Therapeutics Committee (P&T Committee).

The P&T Committee selection of drugs is based on the drugs' efficacy, safety, side effects, pharmacokinetics, clinical literature and cost-effectiveness profile. The medications on the Formulary are organized by therapeutic categories and brand and generic names. The Formulary can be viewed by selecting the "Members" option at www.wellcarepffs.com.

Member Drug Tier Co-pay/Coinsurance

The WellCare Formulary is divided into four tiers: generic, preferred brand, non-preferred brand and specialty drugs. The co-payment and/or coinsurance are based on the drug tier and vary by state. Refer members to the Summary of Benefits found under the "Our Plans" link at www.wellcarepffs.com for the exact co-pay/coinsurance in their state and county.

Additions and Exceptions to the Formulary

To request consideration for inclusion of a drug on the plan's Formulary, please write or fax the plan, explaining the medical justification. Requests should be submitted on the Drug Evaluation Review (DER) form, which can be found at www.wellcarepffs.com/provider/forms.

Generic Medications

Generic drugs are equally effective, but generally less costly, than brand name medications. Their use can contribute to cost-effective therapy. Generic drugs must be dispensed by the pharmacist when a therapeutic equivalent to a brand name drug is available.

Medical justification is required for exceptions to the mandatory generic policy when a therapeutic equivalent is available. An exception request should be submitted on the Drug Evaluation Review (DER) form, which can be found at www.wellcarepffs.com/provider/forms or in the Forms Section of this guide.

Injectable and Infusion Services

Selected self-injectable and infusion drugs are covered under the outpatient pharmacy benefit. Most self-injectable products and all infusion drugs are supplied by a specialty vendor. Specialty drugs require a Drug Evaluation Review (DER) and are not available through the retail pharmacy network. To obtain authorization, the provider must submit the Injectable/Infusion Prescription Order Form to the WellCare Pharmacy Department. The form can be found in the back of this guide or at www.wellcarepffs.com/provider/forms. Fax the completed form to the WellCare Pharmacy Department's toll-free at 1-877-277-1809. The Pharmacy Department will respond to all requests within 72 hours and, if authorized, will coordinate delivery of the product.

Regarding criteria related to specific drugs, please contact the Pharmacy department via our Provider Service Center at 1-866-235-2770.

Covered Medications

All dosage forms and strengths of drugs listed on the Formulary are eligible for coverage unless specified otherwise. Conventional dosage forms such as immediate release tablets/capsules are generally the most economical, unless significant compliance issues exist.

The Formulary applies only to medications obtained through outpatient community pharmacies, and does not apply to drugs used in the hospital.

Coverage Limitations

Coverage of medications is limited to The Food and Drug Administration (FDA) approved indications. Recommended monthly drug quantities and daily supply limits on the Formulary reflect FDA approved dosing. WellCare PFFS does not cover:

- Barbiturates, with the exception of butalbital/codeine combinations that are covered
- Benzodiazepines
- Drugs used to treat anorexia
- Drugs used for weight loss or gain
- Drugs used to treat infertility
- Drugs used to promote hair growth
- Drugs used for cosmetic purposes
- Drugs used for erectile dysfunction
- Cough and cold medications
- Over-the-counter (OTC) items and vitamins**
- Experimental drugs
- Less than effective DESI drugs or drugs that may have been determined to be identical, similar or related

**Some of the WellCare PFFS plans may offer its members a selection of personal care items, which are over-the-counter (OTC) items, including but not limited to vitamins, first aid supplies, analgesics and miscellaneous items.



These items are not dispensed at the pharmacy. They are mailed directly to the member upon request via the Customer Service department and must be selected from an approved list supplied by WellCare.

Step Therapy Programs

Step therapy programs are programs developed by the Pharmacy and Therapeutics Committee. These programs are designed to provide our members with clinically sound, cost-effective drug treatment options. Step therapy programs encourage the use of select therapies before alternative therapies are prescribed. They follow an extensive review of clinical literature, manufacturer product information and consultation with medical professionals to assure a clinically comprehensive program.

Drug Evaluation Review (DER) Process

The goal of the Drug Evaluation Review (DER) program is to ensure that medication regimens that are high risk, have high potential for misuse or have narrow therapeutic indices are used appropriately and according to FDA approved indications. The DER process is required for:

- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity maximum
- Most self-injectable and infusion medications
- Drugs not listed on the Formulary
- Some Formulary drugs that requiring a prior authorization
- Prescriptions that exceed \$1,000 per prescription (some exceptions apply), and/or plan limitations
- Brand name requests when a generic exists
- Drugs that have a step edit and where first line therapy is inappropriate

Obtaining a Drug Evaluation Review (DER)

To obtain a Drug Evaluation Review (DER) complete the Drug Evaluation Review (DER) Form. This form is located in the Form section at the back of this guide and at www.wellcarepffs.com/provider/forms. Fax the completed form to the WellCare Pharmacy department's toll-free at 1-877-277-1809.

Our standard is to respond to DER requests within 72 hours.

Please provide pertinent medical history and information when submitting a DER form for a Formulary exception.

If the DER meets the approved Pharmacy and Therapeutics Committee (P&T Committee) protocols and guidelines, the provider and/or pharmacy will be contacted with the DER approval. If the DER is not a candidate for approval based on the approved P&T Committee protocols and guidelines, it is then reviewed by a clinical pharmacist and by the Medical Director for final determination.

For those requests that are not approved, a follow-up Drug Utilization Review (DUR) form is faxed to the provider stating why the DER was not approved. In addition, the DUR form lists the preferred drugs that are available as alternatives. A denial letter is sent to the member.

Redetermination

If you want to appeal a decision that was denied through the Drug Evaluation Review (DER) process, you should use our redetermination process. This appeal must be filed within 60 calendar days of the denied DER. A member or the prescribing provider may file a redetermination. A member's representative, including any provider who is not the prescribing provider, may also file a redetermination if he/she submits a completed Appointment of

Representation Form with the redetermination. This form can be found in the back of this guide and at www.wellcarepffs.com/provider/forms.

There are two types of redeterminations—expedited and standard. The request for a expedited appeal must document that the standard process time frame would jeopardize the member's health status. Expedited reviews will be completed within 72 hours. Standard appeal requests will be reviewed within seven calendar days.

Members can make a redetermination request by contacting WellCare Customer Service, at the toll-free phone number found on their member ID card. To make a request via fax a member, their appointed representative or the prescribing provider should complete the Redetermination Form found in the Form section of this guide or at www.wellcarepffs.com/provider/forms. He/she should send this form and any other necessary documents to the WellCare Pharmacy department at 1-813-262-2907.

IRE Reconsideration

If we deny any part of a redetermination, then a member or his/her appointed representative may file a request for review with an independent entity contracted by CMS, Maximus. This independent review entity (IRE) contracts with the federal government and is not a part of WellCare PFFS. Only a member or his/her appointed representative may file a reconsideration request. A member may appoint a representative by completing the Appointment of Representative Form. This form can be found in the back of this guide and at www.wellcarepffs.com/provider/forms.

A request for review by the IRE must be made in writing within 60 calendar days of the date on the redetermination. There are two types of reconsiderations—expedited and standard. The request for a expedited appeal must document that the standard process time frame would jeopardize the member's health status. For an expedited decision about a Part D drug that a member has not received, the IRE has up to 72 hours from the time it gets the request to give a decision. For a standard request, the IRE has up to seven calendar days from the date it gets the request to give a decision.

The contact information for this IRE and the IRE Reconsideration Form can be found in the back of this guide and at www.wellcarepffs.com/provider/forms.

Disclosure of Information

Periodically members may inquire as to the operational and financial nature of their health plan. In accordance with federal and state disclosure requirements, WellCare's PFFS Plan will provide that information to the member upon request. Members can request the above information verbally or in writing by contacting WellCare Customer Service.

BEHAVIORAL HEALTH | Section 9

Behavioral health services are provided according to Medicare benefit plan limitations. Please note that inpatient mental health services are limited to a maximum of 190 days per lifetime. This lifetime benefit begins when a member enrolls in Medicare and continues under WellCare's PFFS plan.

QUALITY IMPROVEMENT | Section 10

The Quality Improvement Program has a systematic process for monitoring, identifying and evaluating quality process. This is performed through the collection of plan-wide data including, but not limited to: claims, administrative and provider data. The Quality Improvement Program utilizes a variety of assessment methods to monitor and evaluate the quality of care and services. These methods include medical record reviews, retrospective case reviews, claims reporting, member and provider satisfaction survey results, plan process information, and provider performance reports. Assessment activities include the use of criteria, clinical and service performance indicators, established practice guidelines, and benchmark performance goals. WellCare's PFFS plan participates in specific reviews and tasks applicable to the Medicare Quality Improvement Organization (QIO) programs. These reviews are focused on improving care for beneficiaries. Providers may be asked to participate in quality improvement functions and tasks required by the QIO. These activities may include, but are not limited to:

- Compliance with requests for medical records for use in quality improvement studies and audits
- Cooperation with quality improvement initiatives related to QIO collaborative projects
- Cooperation with QIO efforts to improve care for chronic disease and/or preventive care measures
- Compliance with requests for information and recommendations formulated by the QIO in the process of reviewing/resolving beneficiary and/or provider complaints

CMS will also perform annual audits. Providers will need to copy office records for these audits. It is very important that the entire record be sent any time a copy of a record is requested.

If the member is concerned about the quality of care he or she has received, he or she may also file a complaint with the local QIO. The QIO is an entity paid by CMS to review medical necessity, access to care, appropriateness, and quality of specific medical care and services provided to Medicare Advantage beneficiaries by practitioners.

FRAUD AND ABUSE | Section 11

WellCare's PFFS plan is committed to the prevention and deterrence of Medicare fraud and abuse in compliance with federal laws, regulations and contractual requirements. Billions of dollars are lost to health care fraud and abuse every year for services, equipment and supplies that were never provided to members, procedures that were coded at a higher level than the actual services performed, unauthorized persons using identification cards of legitimate members to obtain health care to which they were not entitled, and other fraudulent or abusive practices. We encourage your support in preventing, detecting, and reporting suspected health care fraud and abuse to the plan.

What Is Fraud?

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable federal law.

Some examples of Medicare fraud include:

- Falsifying medical records, notes, diagnostic test results, reports, claims, or any financial, administrative, or clinical documents used to validate services.

- Billing for services, supplies or equipment not furnished to or used by a plan member.
- Misrepresentations of dates, frequency, duration or description of services rendered or misrepresentations as to the identity of the recipient or provider of services.
- Duplicate billings, i.e., billing more than once for the same service, multiple providers billing for the same service for the same member on the same day, billing the plan and the member for the same services or submitting claims to both the plan and other third parties without making full disclosure of relevant facts to all parties.
- Providing payment or other inducements to a plan member in exchange for the use of his/her identification card, or using plan member identification information with or without the permission of the plan member to submit claims for the purpose of obtaining wrongful payment.

What Is Abuse?

Abuse means provider practices that are inconsistent with sound fiscal, business or medical practices that result in unnecessary cost to the Medicare program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicare program.

Examples of Medicare abuse include:

- A pattern of waiving member (patient) co-pay or deductible.
- Direct or balance billing of WellCare PFFS members.
- A pattern of claims for services that are not medically necessary, or if necessary, not to the extent rendered.
- Providing health care services of inferior quality, i.e., services that do not meet accepted standards of care.
- Failure to maintain adequate clinical or financial records, or failure to furnish requested records.

Reporting Suspected Fraud and Abuse

- WellCare's PFFS plan encourages you to report incidents of suspected Medicare fraud and abuse. If you believe someone may be committing Medicare fraud or abuse, we would like to hear from you. Carefully review the facts as you know them and write them down. Some important information that you should include in your report are:
 - The names, addresses and telephone numbers of those involved in any instance of suspected Medicare fraud or abuse.
 - Any other identifiers such as a Social Security number or federal tax identification number of those suspected of Medicare fraud or abuse.
 - The date(s), time(s) and location(s) of the suspected Medicare fraud or abuse.
 - The name, address and telephone number of any witnesses or victims of the suspected Medicare fraud or abuse.
 - A clear description of what happened and why you believe the incident you are reporting is Medicare fraud or abuse.

To report suspected Medicare fraud or abuse, please contact the toll-free confidential Compliance Program Hotline at 1-866-678-8355. This hotline is available at all times. Additionally, please feel free to contact the Office of Inspector General (OIG) hotline at 1-800-HHS-TIPS (800-447-8477) to report any fraud or misconduct relating the Medicare program, or you can utilize the HHSTips@oig.hhs.org e-mail hotline.

A Special Bulletin regarding enrollment and infusion therapy fraud:

There has been a marked increase in medical identity theft, which has resulted in fraudulent enrollment practices and false claims being submitted in furtherance of the enrollment. Multiple beneficiaries are being moved, without their knowledge, from plan to plan, and infusion therapy claims are being submitted even though the beneficiary has never received the service. If you suspect or have any knowledge related to this scheme, please follow the reporting guide as listed above.

You may also report suspected health care fraud and abuse in writing to the corporate Special Investigations Unit at:

WellCare Health Plans, Inc.
 Attn: Director, Special Investigations Unit
 P.O. Box 31407
 Tampa, FL 33631-3407

MARKETING GUIDELINES | Section 12

CMS has strict Medicare marketing guidelines that are critical for WellCare to maintain. Medicare marketing guidelines apply to WellCare as well as its agents, providers and downstream entities. If you are a provider, please follow the basic rules below.

DO

Do comply with Medicare Marketing Guidelines as provider specific guidelines define how providers may assist beneficiaries with plan selection, while ensuring plan selection is in the best interests of the beneficiary.

Do assist a beneficiary in an objective assessment of the beneficiary's needs and potential plan options that may meet those needs.

Do inform beneficiaries where they may obtain information on the full range of plan options by directing beneficiaries to other sources of information, such as the State Health Insurance Assistance Programs, plan toll free information lines, their State Medicaid Office, local Social Security Administration Office, www.medicare.gov or 1-800-MEDICARE.

Do work with the plan sponsor to announce affiliations and contractual arrangements to beneficiaries.

DON'T

Don't steer or attempt to steer an undecided potential enrollee toward a plan, or limited number of plans based on the financial interest of the provider.

Don't use any affiliation communication materials that describe plans in any way (e.g., benefits, formularies) without prior approval from the plan sponsor. Note: these materials must have CMS-approval prior to distribution.

Don't announce affiliations and contractual arrangements to beneficiaries without first working with the plan sponsor. Subsequent announcements must include all provider plan affiliations.



FORMS | Section 13

A	Advance Coverage Determination	To be used to obtain a written advance coverage determination (also known as an organization determination) from us before furnishing a service in order to confirm whether the service is medically necessary and will be covered by WellCare PFFS.
B	Appointment of Representative Form	To be used when acting on behalf of a member in connection with a claim or an asserted right under Title XVIII of the Social Security Act (the “Act”) and related provisions of Title XI of the Act.
C	Provider Claim Payment Resolution Process Form	To be used if you believe that the payment amount you received for a service is less than the amount indicated in our Terms and Conditions of Payment. Submit this form along with a copy of the claim being disputed and all supporting documentation.
D	Provider PFFS Appeal Form	To be used when submitting a provider appeal for medical necessity and/or benefits. Submit this form along with all additional, appropriate appeal forms and medical records.
E	Waiver of Liability Form	To be used when using the member’s appeal process. It promises you will hold the member harmless regardless of the outcome.
F	W-9 Form— Request for Taxpayer Identification Number and Certification	To be used to submit your tax identification number and certification either for the first time or anytime your tax information changes.
Pharmacy/Prescription Drug Forms		
G	Injectable/Infusion Prescription Order Form	To be used for an injectable infusion prior authorization request.
Drug Evaluation Process Forms		
H	Drug Evaluation Review (DER) Form	To be used to determine coverage for medication prior authorizations, non-formulary medications and medications with utilization management rules.
I	Redetermination Form	To be used when you want us to reconsider and change a decision we have made about what prescription drug benefits are covered or what we will pay for a prescription drug. In order to file an appeal, you must first go through the Drug Evaluation Review (DER) process.
J	IRE Reconsideration Form	If the decision of the prescription drug appeal (redetermination) is to continue the denial of coverage or payment, then the member or the member’s appointed representative has the right to file a request for reconsideration with Maximus, a company contracted by Medicare to review managed care organization denials. This is the form that should be used for that process.

FAX TRANSMITTAL COVER SHEET



PFFS Advanced Coverage Determination

From: To: PFFS Advance Coverage Determination

Fax: Fax: 1-813-464-8764

Phone Number:

Pages: (including cover page)

Subject: PFFS Advance Coverage Determination

WellCare PFFS will make a decision and notify you within 14 days of receiving the request, with a possible 14-day extension either due to the member's request or WellCare PFFS justification that the delay is in the member's best interest. In cases where you believe that waiting for a decision under this time frame could place the member's life, health or ability to regain maximum function in serious jeopardy, you can request an expedited determination. To obtain an expedited determination, call us at 1-866-235-2770 or check the box at the bottom of this form. For expedited determinations, we will notify you of our decision within 72 hours.

Please provide the following information:

Member	
Member Plan ID:	Today's Date:
Member Last Name:	Member First Name:
Member Phone Number:	Date of Birth:
Requesting Provider	
Provider ID:	Type: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist
Provider Last Name:	Provider First Name:
Phone Number:	Fax Number:
Address: _____ City: _____ State: _____ ZIP: _____	
Phone Number:	Fax Number:

Privacy Notice:

This facsimile message and any attachments are intended for the exclusive use of the addressee(s) and may contain information that is proprietary, confidential and/or exempt from disclosure and may be Protected Health Information. If you are not the intended recipient, please notify us immediately by calling the number below and return the original message to us at the address below via the US Postal Service. We will reimburse you for your postage. If you are a regular recipient of our faxes, please notify us if you change your fax number. Thank you.

WellCare Health Plans, Inc.
Attention: Chief Privacy Officer
8735 Henderson Road, Ren. 2
Tampa, FL 33634
Phone: (813) 290-6200

**FAX TRANSMITTAL
COVER SHEET**



PFFS Advanced Coverage Determination

Facility			
Place of Service: Office/clinic	OP Hospital	Free Standing Facility	Home
Facility ID:		Facility Name:	
Address:		City:	State: ZIP:
Phone Number:		Fax Number:	
Service Requested			
Planned Date of Service: From: ___/___/___ To: ___/___/___			
Primary ICD-9 Code:		Description:	
CPT- 4 / HCPC Code	Description of Procedure or Services	Visits / Frequency	
Please include additional procedure codes, as applicable, in the Clinical Summary below.			
Pertinent Clinical Summary: (Attach supporting clinical records, if necessary). For customized equipment or services, specify pertinent member information (i.e., height, weight, O ₂ saturation, sleep study, functional assessment, etc.)			

Expedited Review (*Defined as medically necessary treatment for an injury, illness, or other type of condition—usually not life threatening—which should be treated within 24 hours.*)

Provider Service Center: 1-866-235-2770 (TTY/TDD: 1-866-239-6265) Monday–Sunday, 7am to 2am Eastern

Privacy Notice:

This facsimile message and any attachments are intended for the exclusive use of the addressee(s) and may contain information that is proprietary, confidential and/or exempt from disclosure and may be Protected Health Information. If you are not the intended recipient, please notify us immediately by calling the number below and return the original message to us at the address below via the US Postal Service. We will reimburse you for your postage. If you are a regular recipient of our faxes, please notify us if you change your fax number. Thank you.

WellCare Health Plans, Inc.
Attention: Chief Privacy Officer
8735 Henderson Road, Ren. 2
Tampa, FL 33634
Phone: (813) 290-6200

APPOINTMENT OF REPRESENTATIVE

NAME OF BENEFICIARY	MEDICARE NUMBER
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SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the beneficiary:

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF BENEFICIARY		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This form should be filled out if the representative waives a fee for such representation.

(Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

SIGNATURE	DATE
-----------	------

SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

SIGNATURE	DATE
-----------	------

CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Provider PFFS Appeal for Medical Necessity and/or Benefits Denials Request Form

Provider Appeal for Medical Necessity and/or Benefits Process for WellCare Private Fee-for-Service (PFFS)*

A provider has sixty (60) days from the date of the initial determination to submit a medical necessity and/or benefit appeal.

- This form, all additional, appropriate appeal forms and medical records should be:
 - o Mailed to
WellCare Health Plans, Inc., Attn: PFFS Provider Appeals
P.O. Box 31368, Tampa, FL 33631
 - o Or faxed to: 1-866-201-0657 (if less than 10 pages)
- Provider appeals will be resolved, in writing, within sixty (60) days of initial receipt of the appeal by WellCare.

A provider may also appeal decisions on behalf of a member as an appointed representative, or appeal on his or her own right using the member’s appeal process by signing a waiver of liability (promising to hold the member harmless regardless of the outcome). There must be existing potential member liability in order for a provider to appeal utilizing the member’s appeal process. To view all the details of the process visit <http://www.wellcarepffs.com/provider/terms> and see the section “Member and Provider Appeals and Grievances.”

Request Date: _____

Bundled Request? Yes No

Has the service been provided yet? Yes No

Expedited Request? Yes No
(See reverse side for definition of Expedited Request)

Provider/Appellant Information

Provider 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: _____

Claim Number: _____

Reason Given for Denial (from EOB or denial letter):	
<input type="checkbox"/>	Medical Necessity
<input type="checkbox"/>	Lack of Information
<input type="checkbox"/>	Benefits Exhausted
<input type="checkbox"/>	Out of Network
<input type="checkbox"/>	Not a Covered Benefit
<input type="checkbox"/>	Other:

***Please note** this is **not** the form to use if you have a claims payment dispute. That form, Provider Claim Payment Resolution Process Form, can be found at www.wellcarepffs.com/provider/forms.

Appendix 6 - Waiver of Liability Statement

(Rev. 22, 05-09-03)

WAIVER OF LIABILITY STATEMENT

Medicare/HIC Number

Enrollee's Name

Provider

Dates of Service

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 42 CFR 422.600.

Signature

Date

Request for Taxpayer Identification Number and Certification

Give form to the
requester. Do not
send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)	
Business name, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	
List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number : : : :
OR
Employer identification number : : : :

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
2. The United States or any of its agencies or instrumentalities,
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,
7. A foreign central bank of issue,
8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
9. A futures commission merchant registered with the Commodity Futures Trading Commission,
10. A real estate investment trust,
11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
12. A common trust fund operated by a bank under section 584(a),
13. A financial institution,
14. A middleman known in the investment community as a nominee or custodian, or
15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 7 ²

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting www.irs.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.consumer.gov/idtheft or 1-877-IDTHEFT(438-4338).

Visit the IRS website at www.irs.gov to learn more about identity theft and how to reduce your risk.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship or disregarded entity owned by an individual	The owner ³
For this type of account:	Give name and EIN of:
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

²Circle the minor's name and furnish the minor's SSN.

³You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.



WELLCARE INJECTABLE INFUSION FORM

Prior Authorization Request for WellCare Medicare/ Private Fee for Service (PFFS)
FAX to 1-877-277-1809 WellCare Pharmacy - Injectable Infusion Department

Who is making this request? Provider Member

Appointed Representatives: Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

Complete each section legibly and completely (include any additional necessary medical records or laboratory results)	Date Submitted
--	----------------

Member ID #					Provider ID#					
Name					Name					
Address					Address					
City		State		Zip	City		State		Zip	
Phone					DOB					
Height		Wt lb/ Kg		Dx						
Allergies					ICD9					
					Contact					
					Phone			Fax		
					Alt Phone			Fax		

Medication	Dose	Frequency	Length of Treatment

Physician Signature:

Clinical Reason for override (Include medications tried and failed, laboratory values, or any other pertinent information). Please fax additional pages as necessary.

Does the member reside in a long term care facility (LTC)? Yes No

Will the medication be sent to the provider's office for administration? Yes No

If Yes: Pharmacy is responsible for collecting the medication co-payment/co-insurance from the patient. Drugs Will Not be sent until payment is received.

Send to address listed above? Yes No Send to:

Name _____

Address _____

City, State, ZIP _____ Phone : _____

Will physician supply and administer medication in the office ? Yes No

If Yes: Physician's office is responsible for collecting medication co-payment/co-insurance from the patient.

Is the Medication being administered at the patient's home? Yes No

Is the medication being administered at a facility or outpatient center? Yes No

Facility Name/Outpatient Clinic: _____ Facility Name/Outpatient Clinic Provider ID#: _____

REQUEST FOR EXPEDITED REVIEW (24 HOURS)

I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.



Medicare Coverage Determination Request Form

Instructions: This form is used to determine coverage for prior authorizations, non-formulary medications (see formulary listings at www.wellcare.com), and medications with utilization management rules. WellCare will evaluate the request based on medical criteria, FDA guidelines and protocols developed by the WellCare Pharmacy & Therapeutics Committee.

Who is making this request?

Provider

Member

Appointed Representatives: Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

The following review criteria are used in reviewing drug evaluations and requests for overrides:

- Patient has tried and failed an appropriate trial of generic or preferred medications.
- Other therapeutically equivalent medications are contraindicated in the patient.
- Choices available are not suited for the present patients care and the medication requested is required for patient safety.
- An alternative choice may provoke an underlying medical condition, which would be detrimental to the care of the patient.

Complete each section legibly and completely (include any additional necessary medical records)

Member Name		Date of Request
WellCare ID #	State:	Physician Name
Date of Birth	Pt currently in LTC? Yes or No	Physician Signature
Member's Telephone Number		Specialty
Diagnosis of Requested Medication		Sent by
Medication Requested		Physician Phone #
Dose	Dosage Form	Physician Fax #
Directions for Use	Quantity	Pharmacy Phone #
Duration of Therapy		Pharmacy Fax #
Clinical reason for override (previous medications tried and failed and any other pertinent Details). Please fax additional supporting pages as necessary.		

REQUEST FOR EXPEDITED REVIEW (24 HOURS)

BY CHECKING THIS BOX, THE PRESCRIBING PHYSICIAN INDICATED ABOVE OR PHYSICIAN'S AGENT CERTIFIES THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.

FAX to: WellCare Pharmacy at 1-877-277-1809

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

MEDICARE REDETERMINATION REQUEST FORM

1. Beneficiary's Name: _____
2. Medicare Number: _____
3. Description of Item or Service in Question: _____
4. Date the Service or Item was Received: _____
5. I do not agree with the determination of my claim. MY REASONS ARE:

6. Date of the initial determination notice _____
(If you received your initial determination notice more than 120 days ago, include your reason for not making this request earlier.)

7. Additional Information Medicare Should Consider: _____

8. Requester's Name: _____
9. Requester's Relationship to the Beneficiary: _____
10. Requester's Address: _____

11. Requester's Telephone Number: _____
12. Requester's Signature: _____
13. Date Signed: _____
14. I have evidence to submit. (Attach such evidence to this form.)
 I do not have evidence to submit.

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.

Instructions for submitting a Medicare Redetermination request form:

Members may return completed forms by fax or mail.

Fax number: **1-866-201-0657**

Mailing Address:

WellCare
P.O. Box **31368**
Tampa, FL 336 **31-3368**

If members have any questions when completing this form they should call WellCare at 1-888-888-9355 (TTY users, 1-877-247-6272), Monday – Friday 8:00am – 10:30pm EST.

MEDICARE RECONSIDERATION REQUEST FORM

- 1. Beneficiary's Name: _____
- 2. Medicare Number: _____
- 3. Description of Item or Service in Question: _____
- 4. Date the Service or Item was Received: _____

5. I do not agree with the determination of my claim. MY REASONS ARE:

6. Date of the redetermination notice _____
(If you received your redetermination more than 180 days ago, include your reason for not making this request earlier.)

7. Additional Information Medicare Should Consider: _____

8. Requester's Name: _____

9. Requester's Relationship to the Beneficiary: _____

10. Requester's Address: _____

11. Requester's Telephone Number: _____

12. Requester's Signature: _____

13. Date Signed: _____

- 14. I have evidence to submit. (Attach such evidence to this form.)
 I do not have evidence to submit.

15. Name of the Medicare Contractor that Made the Redetermination: _____

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.

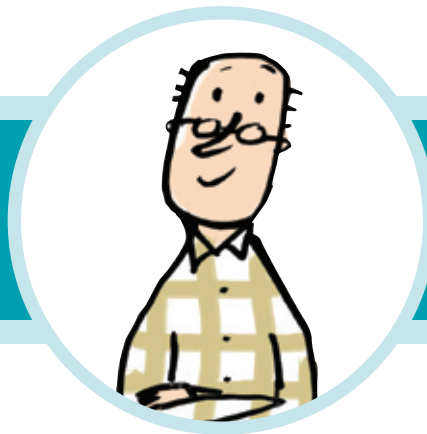
Instructions for submitting a Medicare Reconsideration request form:

Members may return completed forms by fax or mail.

Fax number: 1-484-688-5601

Mailing Address:

Maximus
1040 First Avenue
Suite 200
King of Prussia, PA 19406



Contact Us

Provider Service Center

1-866-235-2770 (TTY/TDD: 1-866-239-6265)

Monday–Sunday, 7am to 2am Eastern

The forms and procedures you may need are also available on our Web site at www.wellcarepffs.com/provider.

Important fax numbers:

- Provider payment dispute resolution fax: 1-866-473-9122
- Provider appeal for medical necessity and/or benefits fax: 1-866-201-0657
- Provider advance determination fax: 1-813-464-8764
- Provider Pharmacy (Coverage Determination form) fax: 1-877-277-1809
- Provider Pharmacy (Appeals) fax: 1-813-262-2907