Request for Reconsideration and Claim Dispute Form

Use this form as part of the Wellcare By Allwell Request for Reconsideration and Claim Dispute process.

All fields are required information:

Provider Name:	**Provider Tax ID Number:**
Control/Claim Number:	**Date(s) of Service:**
Member Name:	**Member ID Number:**

Please Note:

- A Request for Reconsideration (Level I) is a communication from the provider about a disagreement on how a claim was processed.
- A Claim Dispute (Level II) should be used only when a provider has received an unsatisfactory response to a Request for Reconsideration.
- The Request for Reconsideration or Claim Dispute must be submitted within 90 Days from the date on the original Explanation of Payment (EOP) or denial.
- Any photocopied, black and white, or handwritten claim forms, regardless of the submission type (first time, corrected claim, Request for Reconsideration, or Claim Dispute) will cause an upfront rejection.
- If the original claim submitted requires a correction, please submit the corrected claim following the "Corrected Claim" process in the Wellcare By Allwell provider manual, found on SuperiorHealthPlan.com/ProviderManuals. Please do not include this form with a corrected claim.

Levels of Dispute:

- Level I - Request for Reconsideration. (Attach medical records for code audits, code edits or authorization denials. Do not attach original claim form.)
- Level II – Claim Dispute. (Attach the following: 1. a copy of the EOP(s) with the claim numbers to be adjudicated clearly circled 2. the response to your original Request for Reconsideration. Do not attach original claim form.)

Reason for Dispute (please check one):

- ☐ Claim was denied for no authorization, but the following authorization number was obtained: _____
- ☐ Claim was denied for no authorization, but no authorization is required for this service.
- ☐ Claim was denied for untimely filing in error (attach proof of timely filing).
- ☐ Claim was denied for global/unbundled procedure (attach medical records).
- ☐ Claim was paid to the wrong provider.
- ☐ Claim was paid for the incorrect amount.
- ☐ Other (please explain):

_____

_____

Requestor Name:	
Requestor Phone Number:	**Date of Request:**

Mail completed form(s) and attachments to the appropriate address:

Wellcare By Allwell
Attn: Level I - Request for Reconsideration
PO Box 3060
Farmington, MO 63640-3822

Wellcare By Allwell
Attn: Level II – Claim Dispute
PO Box 4000
Farmington, MO 63640-4400