By allwell™

Medicare Reconsideration Form

Date: ____________

Please complete the following form within 180 days to help expedite the review of your claims reconsideration.

*Is this a

Request for Reconsideration: you disagree with the original claim outcome (payment amount, denial reason, etc.) Please check if this is the first time you are asking for a review of the claim.

Claim Dispute: you disagree with the outcome of the Request for Reconsideration

Member Name:

Member ID:

Date(s) of Service:

Control/Claim Number(s):

Medicare Remittance Date:

Billed Charge(s):

Provider NPI:

Provider TIN:

Provider Name:

Provider Contact Number:

Contact Name:

Contact Address:

Reason for the reconsideration (please check all that apply):

Claim was denied for no authorization, but authorization number was obtained.

Claim was denied for no authorization, but no authorization is required for this service.

Claim was denied for Member not eligible, but member was eligible on DOS (attach eligibility information)

Claim was denied for incomplete or missing sterilization form, but one was submitted with claim (attach completed form)

Claim was not paid per the terms of my contract with SilverSummit Healthplan (attach relevant reimbursement section)

Claim was denied “Past Timely Filing” (attach proof of timely filing)

Claim was paid the incorrect amount (include calculation of expected payment and supporting information

Other: Please explain :

Please ensure sufficient detail is provided to assist us in the review of your reconsideration or dispute. Mail completed forms and all attachments to:

For Requests for Reconsideration

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

For Claim Disputes

Wellcare By Allwell
Attn: Claim Dispute
PO BOX 4000
Farmington, MO 63640-4400