

Medicare Advantage Provider Appeal Form

Follow the steps below to submit an appeal request to Wellmark Advantage Health Plan.

A. Provider information:

What type of appeal?
Standard
Expedited

Is this a Part B Drug Appeal:	Yes	No
(if Yes, What is the name of the drug?)		
Drug Name:		
(Note: Part D Drug Appeals are not part of this form)		

Provider (e.g.: doctor's name, hospital, laboratory):		
Address:	City/State:	ZIP code:
NPI #:	Tax ID #:	
Provider Contact Name:	Phone #:	Fax #:

B. Member information:

First Name:	Last Name:	Date of Birth: MM/DD/YYYY
Membership ID#: (include all characters):		Group #:

C. What are you appealing?

Please select one of the type of request (if known):
Level I Appeal
Level II Appeal
Payment Disputes

Please select one of the options:
Pre-Service
Post-Service
Payment Dispute

Please provide information below:

Date of Service: MM/DD/YYYY	Claim Number:	Total Charge:
Utilization Management Case #: (listed on denial letter)		

Note: Please include all supporting documentation with your request

D. Tell us why you are appealing:

What would you like us to review again? Write in the space below and be sure to attach supporting documents. (750 Character Limit)

What action do you want us to take? Write in the space below. If you need more space, please attach a written statement. (750 character limit)

E. Send to the appeals department:

Please select if you are: Contracted Provider Non-Contracted Provider

Applicable Information Per Provider Type

Contracted Provider

- Dispute Types
 - Inclusive procedures/clinical edits
 - Allowed amount not applied per provider's contract
 - Multiple modifier reimbursements

Non-Contracted Provider

- Submit within 60 calendar days from the date of the remittance advice
 - Waiver of Liability (Required)
 - Good Cause Request (if applicable)

Send to:

Fax: 1-866-533-6950
Wellmark Advantage Health Plan Appeals & Grievances
PO Box 211483
Eagan, MN 55121