PDP Appeal Request

(REDETERMINATION)

Please fax completed form and medical records to:

1-866-388-1766

You may reach us by phone at 1-888-550-5252 for any questions.

Please complete each section legibly.

Member Name	**Date of Request**	**Requester's Name & Relationship To Member**
Health Plan ID#		STATE of Member's residence: Plan type Signature Complete Premier
DOB		Physician Name
Diagnosis		Specialty
Drug Name		Contact Person
Dose		Physician's Phone
Dosage Form/Strength		Physician's Fax
Qty		Pharmacy Phone
Length of Treatment		
Clinical Reason for Appeal (include medical documentation)		
History/Allergies		Wellcare use only: RD_____ DD_________ Tech_ ____ date_____ RPh ___ _____ date______ MD______ ____ date_______

Instructions for submitting a **PDP Appeal Request**
(Redetermination form):

Providers may return completed forms by fax or mail.

Fax number: **1-866-388-1766**

Mailing Address:
WellCare
P.O. Box 22348
Tampa, FL 33622

If providers have any questions when completing this form they should call WellCare at
1-888-550-5252 (TTY users, 1-888-816-5252), Monday – Friday 7:00am – 10:30pm EST.