

Medicaid Medication Appeal Request Forms

Because <WellCare> Health Plans denied your request for coverage of (or payment for) a prescription drug, you have the right to an appeal. The means you may ask us to review our decision. You have <All except CHP & BHP: 60 days, CHP: 45 days, BHP: 180 days> from the date of our Notice of Adverse Benefit Determination to ask us for an appeal. To start the appeal, please fill out this form and send it to us by mail or fax:

<Address:
WellCare
P. O. Box 31383
Tampa, FL 33631>

<Fax Number:
1-866-388-1766>

You may also ask us for an appeal through our website at <www.wellcare.com>.

Important Note: Expedited Decisions

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN <24 HOURS/48 HOURS/72 HOURS>**

If you have a supporting statement from your Primary Care Provider (PCP), please

If you or your PCP believe(s) that waiting **<15 days/30 days>** for a **standard decision** could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. We will automatically make a decision **within <24 hours/48 hours/72 hours>** if your PCP tells us that waiting **<15 days/30 days>** could seriously harm your health. Without your PCP's support for an expedited appeal, we will decide whether your case requires a faster decision. **Please note that you cannot ask for a faster appeal if you are asking us to pay you back for a drug you already received.**

Who is making this request? Provider ☐ Member ☐ Appointed Representative ☐

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

Complete the following section ONLY if the person making this request is not the Member or prescriber:

Requestor's Name		
Requestor's Relationship to Member		
Address		
City	State	Zip Code
Requestor Phone		

Representation documentation for requests made by someone other than Member or the Member's prescriber:

Attach documentation showing the authority to represent the Member (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan.

***REQUIRED FIELDS – ONE MEDICATION PER FORM.**

*Member Name:	
*Member ID #:	*Date of Birth:
*Member Phone:	*Duration (how long therapy lasts): Indefinite? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If the box above is left blank, it will be assumed that the request is indefinite.</i>
*Drug Name/Strength/Form (i.e., tablet, capsule):	*Quantity:
	*Frequency (i.e., how often, how many):
*Generic Substitution Permitted: <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If this field is left blank, it is assumed that the request is for what the pharmacy is processing (if applicable). If there is no pharmacy claims history, it is assumed that the request is the specific form of the drug listed in the *Drug Name field.</i>	
*Associated Diagnosis: <i>list all diagnoses and ICD-10 codes being treated with the drug.</i>	
*Submitting Provider NPI:	*Provider Name (First Name & Last Name):
*Provider Mailing Address (including city, state, ZIP):	
*Provider Phone:	*Provider Fax:
*Office Contact Name:	*Provider Signature:
Pharmacy Name:	Pharmacy Phone:
*Drug Allergies:	
DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)	
Drugs Tried: if quantity limit is an issue, list unit dose/total daily dose tried	RESULTS of previous drug trials. Indicate FAILURE vs INTOLERANCE (explain)
What is the Member's current drug regimen for the condition(s) requiring the requested drug?	

Please explain your reasons for appealing. Use the space below and attach additional pages, if needed. Attach any information you believe may help your case, such as a statement from your PCP and relevant medical records. You may want to refer to the explanation we provided in the Notice of Adverse Benefit Determination.

Signature of person requesting the appeal (the member, or the member’s PCP or representative): _____

Date: _____

Discrimination is Against the Law

WellCare of Kentucky complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. WellCare of Kentucky does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

WellCare of Kentucky provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

WellCare of Kentucky also provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call us toll-free at **1-877-389-9457** (TTY: **711**). We're here for your Monday–Friday from 7 a.m. to 7 p.m.

If you believe that WellCare of Kentucky has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

EEO/Civil Rights Compliance Branch
Cabinet for Health and Family Services
Office of Human Resource Management
275 E. Main St, Mail Stop 5C-D
Frankfort, KY 40621
Telephone: **1-502-564-7770**
Fax: **1-502-564-3129**
Email/Web: <https://chfs.ky.gov/Pages/civil-rights.aspx>

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the EEO/Civil Rights Compliance Branch is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F
HHH Building
Washington, D.C. 20201
Telephone: **1-800-368-1019, 1-800-537-7697** (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-389-9457** (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-389-9457** (TTY: **711**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-389-9457** (TTY: **711**)。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-389-9457** (TTY: **711**).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-389-9457** (TTY: **711**).

ملحوظة: إذا كنت تتحدث ذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-389-9457** (TTY: **711**).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-389-9457** (TTY: **711**).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-389-9457** (TTY: **711**)번으로 전화해 주십시오.

Opmierksamkeet: Wann du [Deutsch (Pennsylvania German/Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff **1-877-389-9457** (TTY: **711**).

ध्यान दनुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमिति भाषा सहायता सेवाहरू नःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् **1-877-389-9457** (TTY: **711**)।

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-877-389-9457** (TTY: **711**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-389-9457** (TTY: **711**).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-389-9457** (TTY: **711**).

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona **1-877-389-9457** (TTY: **711**).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite **1-877-389-9457** (TTY: **711**).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-877-389-9457** (TTY: **711**) まで、お電話にてご連絡ください。