



PDP Appeal Request

Please fax request to #1-866-388-1766 along with all pertinent medical records.
You may reach us by phone at 1-888-550-5252 for any questions
Please complete each section legibly.

The appeal request is being initiated by: Physician Member Appointed Representative

Member's Name:	Date & Time of Request:	Name person requesting this appeal and their relationship to the member:
Member ID#:		Original Coverage Determination Date:
Date of Birth:		Requestor's Phone Number:
Member's Phone Number:		Requestor's address: (if applicable)
Member's Address:		
Diagnosis:		Requestor's Fax Number: (if applicable)
Medication Name:		Physician's Name:
Medication Strength & Dose:		Contact Person at Physician's office:
Quantity and Day Supply:		Physician Phone:
Length of Treatment being requested:		Physician Fax:
Clinical Reason for Appeal (include medical documentation)		
History/Allergies	WELLCARE USE ONLY WellCare Associate Name: _____ WellCare Associate Location: _____	

[] REQUEST FOR EXPEDITED REVIEW (72 HOURS)

BY CHECKING THIS BOX, THE PRESCRIBING PHYSICIAN INDICATED ABOVE OR PHYSICIAN'S AGENT CERTIFIES THAT APPLYING THE 7 DAY STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.

