Provider ER Medical Review Request Form

❍ **Georgia Families**
❍ **PeachCare for Kids**

Request Date: _____

Provider Information

Name: _____
Address: _____
City: _____
Telephone: _____
Fax: _____
Contact Person: _____

Patient Information

❍ **Multiple Members (List on separate sheet)**

Name: _____
ID Number: _____
Date of Birth _____

Service Provided Information

Date(s) of Service: _____
Place of Service: _____

Explanation of Issue(s):

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Fill out the form completely and keep a copy for your records. Send this form with all documentation to support the appeal request to:

WellCare of Georgia, Inc.
Attn: **Appeals**
P.O. Box 31368
Tampa, FL 33631-3368

You may also **FAX** the request (if fewer than 10 pages) to **(866) 201-0657**.
Your request will be processed once all necessary documentation is received and you will be notified of the outcome. **Failure to submit supporting documentation may delay our response to your appeal.**