Welbe Health

Provider Appeal/Dispute Resolution Request (PDR)

Note: submission of this form constitutes agreement not to bill the participant

- **Contracted providers**: Please submit your request through our portal at https://welbehealth.quickcap.net/ > Click on the PDR module (left hand side) > PDR Submission/Search > Add (then complete all the required fields).
- **Non-contracted providers**: Please complete and send this form (***all fields required***) and any pertinent documentation to: WelbeHealth, Attn: PDR Department, PO Box 30760, Tampa, FL 33630-2760, or via email: Providerappeals@welbehealth.com

PROVIDER INFORMATION

Rendering Provider/Facility Name: _____ NPI: _____
Pay to Affiliate Name: _____ Contact Name: _____
Provider Billing Address: _____ Phone #: _____
City/State: _____ Zip Code: _____

PARTICIPANT INFORMATION

Participant Name: _____ Welbe ID#: _____

Participant Date of Birth: _____ Patient Acct. #: _____

DISPUTE TYPE

☐ Denied Services Dispute*
- ☐The entire claim was denied
- ☐The following services were denied:

If denial was for additional information only, do not submit using this form. Please submit via Correspondence Cover Page.

☐ Underpaid Services Dispute

☐ Overpaid Services Dispute (*If an overpayment exists, please select one option below*)
- ☐ We will mail a refund check to WelbeHealth.
- ☐ Please offset only this refund from future claim payments.

CLAIM INFORMATION

WelbeHealth Claim #: _____
Service Date(s): _____
Expected Pay Amount: _____

ADDITIONAL DISPUTE INFORMATION

Signature Date