WellAway Limited
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Member Appeal Form

Please provide the following information for the primary Insured/Member.
(This information may be found on the front of your ID card.)

Today's Date	Member's ID Number	Plan Type	Member's Group Number *(Optional)*
		☐ Medical ☐ Dental	

Member's First Name	Member's Last Name	Member's Birthdate (mm/dd/yyyy)
Member's E-mail Address		

Please provide the following information for the person you are submitting the request for.

First Name	Last Name	Birthdate (mm/dd/yyyy)
Relationship to person requesting the appeal: ☐ Self ☐ Spouse ☐ Child ☐ Other _____ **Note:** If your selection is spouse, child (18 years of age or older) or other, please complete and include the Authorized Representative Form with your request.		
Please advise if the appeal is related to: ☐ Pre-Service ☐ Post Service		

To help WellAway review and respond to your request, please provide the following information.
(This information may be found on your Explanation of Benefits)

Claim ID Number (If Post Service selected above.)	Reference Number or Prior Authorization Number (If Pre-Service selected above.)	Service Date (If Post Service insert date of services, if Pre-Service insert date of denial.)
Explanation of Your Request (Please use additional pages if necessary.)		
Member's Signature		

Note: When submitting this form with your request please include:
- Bills and/or correspondence for these services.
- Any other helpful information.

You may submit your request via email to: **conciergecare@wellaway.com**

You may mail your request to: **PayerFusion Holdings, LLC**
5200 Blue Lagoon Drive
Suite 100
Miami, Florida 33126

Or use our fax number: **305-384-7059**