Wellpoint
District of Columbia

Enrollee Appeals Request Form

Thank you for choosing Wellpoint District of Columbia, Inc. as your health plan.
If you do not agree with a decision we made, please use this form to contact us.

Enrollee Name:

Parent or Guardian Name (if service is for a child):

Enrollee ID #:

Enrollee Date of Birth:

Name of Doctor Providing the Service:

Authorization Number:

Provider Address:

Provider Office Phone Number(s):

Type of Service You Want:

Reason for Requesting Service:

Date of Service Provided:

Authorized Person/Provider:

Reason for Appeal:

You can submit this form to the Appeals Department by:
Fax: **866-516-4806**
Email: **MedicaidDCGA@elevancehealth.com**
Mail: Wellpoint District of Columbia, Inc.
Enrollee Appeals, P.O. Box 62429, Virginia Beach, VA 23466-2429

By signing, enrollee is providing approval for their provider or other chosen representative to act on their behalf in this appeal.

Signature: Date:

Coverage provided by Wellpoint District of Columbia, Inc.

wellpoint.com/dc/medicaid

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DHCF Department of Health Care Finance

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

This program is brought to you by the Government of the District of Columbia Department of Health Care Finance.