Wellfleet Rare Disease or Condition Notification Form (Minnesota Only)

Wellfleet will not restrict the choice of where to receive services from a licensed health care provider related to the diagnosis, monitoring, and treatment of a rare disease or condition, as defined in MN ST § 62Q.451. This means that cost-sharing and benefit or service limitations for such services rendered by an out-of-network licensed health care provider will be administered at the in-network benefit level.

Please use the attached Wellfleet Rare Disease Notification Form if you or your dependent (if applicable) have a rare disease or condition that:

- affects fewer than 200,000 persons in the United States and is chronic, serious, life-altering, or life-threatening;
- affects more than 200,000 persons in the United States and a drug for treatment has been designated as a drug for a rare disease or condition pursuant to United States Code, title 21, section 360bb;
- is labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health;

Or, if you or your dependent (if applicable):

- have received two or more clinical consultations from a primary care provider or specialty provider that are specific to the presenting complaint;
- have documentation in the enrollee's medical record of a developmental delay through standardized assessment, developmental regression, failure to thrive, or progressive multisystemic involvement; and
- had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnosis.

Note that even if the diagnosis does not meet the definition of rare disease or condition, upon receipt of notice from you, your cost-sharing and benefit or services limitations for the diagnosis and treatment of the disease or condition will be treated at the in-network benefit level for up to 60 days.

To file via facsimile, send to**: [413-781-1958]**

To file via secure email: Set up login at wellfleet-mail.com and register for secure submittal via Zix. Send requests to: clinical@wellfleetinsurance.com.

For further information or questions, please call the phone number listed on the back of the customer's ID card or call Customer Service team (800) 633-7867.

WELLFLEET

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Do not use this form: 1) to request an appeal, 2) to confirm eligibility, 3) to verify coverage, 4) to ask whether a service requires prior authorization, 5) to request prior authorization of a prescription drug, 6) for services that require precertification*, or 7) to request a referral to an out of network physician, facility, or other health care provider.

MEMBER INFORMATION	
Legal Name:	Preferred Name (if different):
DOB:	Address:
Member ID:	Phone/Email:
GENERAL INFORMATION	
REVIEW TYPE: NON-URGENT ☐	URGENT ☐
Clinical Reason for Urgency:	
PROVIDER INFORMATION	
Referring/Requesting Provider Information	**Other Specialist Provider Information**
Name:	Name:
Practice Name:	Practice Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:
Email:	Email:
REQUIRED CLINICAL INFORMATION	
Date of Request:	
Dates of Services:	
Diagnoses (List ICD-10 Codes and Descriptions)	3)
1)	4)
2)	5)
Additional:	
Procedure(s) Requested (List all CPT/HCPCS Codes)	4)
1)	5)
2)	6)
3)	7)
Additional Clinical Information Attached: ☐	Number of Pages: ☐

Completed form and all supporting documentation may be submitted to Wellfleet via fax (413-781-1958) or email clinical@wellfleetinsurance.com.