



P.O. Box 31370
Tampa, FL 33631-3370

Provider Check Tracer Request Form

Please note: Check tracer request can only be initiated **45 days** after the check.

***** Check Copy requests should be referred to your Financial Institution. *****

Provider Information

Request Date

Provider Name:	<input type="text"/>		
Provider ID #:	<input type="text"/>		
Address:	<input type="text"/>		
City:	<input type="text"/>		
State:	<input type="text"/>	Zip Code:	<input type="text"/>
Telephone:	<input type="text"/>		
Fax:	<input type="text"/>		
Contact Person:	<input type="text"/>		

Patient Information

Patient Name:	<input type="text"/>
ID Number:	<input type="text"/>
Date of Birth:	<input type="text"/>
Line of Business:	<input type="text"/>

Check Information

Check#:	<input type="text"/>	Payee:	<input type="text"/>
Paid Date:	<input type="text"/>	Amount: \$	<input type="text"/>
Claim Number(s):	<input type="text"/>		
Reason for Request:	<input type="text"/>		
Correct Address:	<input type="text"/>		
W9 Attached:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you previously called about this issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Fill out the form **completely** and keep a copy for your records. Send this form, with all documentation for your request, to WellCare Health Plans, Inc.: Via fax at **(813)283-3282**, or Via mail at **P.O. Box 31370 Tampa, FL 33631-3370*** Your request will be processed based on date received. Please allow 45 days for check tracer to be completed as you will be notified of the outcome.

Failure to send in your completed form will result in your request **not being processed.*