# 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.**

**Request Date:**

| **Provider Information** | | |
|---|---|---|
| Provider Name: | | Provider ID #: |
| Address: | | |
| City: | State: | ZIP Code: |
| Telephone: | Fax: | Contact Person: |

| **Patient Information** | |
|---|---|
| Patient Name: | ID Number: |
| Date of Birth: | Line of Business: |

| **Check Information** | | | |
|---|---|---|---|
| Check #: | Payee: | | |
| Paid Date: | Amount: $ | Claim Number(s): | |
| Reason for Request: | | | |
| Correct Address: | | | |
| City: | | State: | ZIP Code: |
| W-9 Attached: ☐ Yes ☐ No | Have you previously called about this issue? ☐ Yes ☐ 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.**
**P.O. Box 31370**
**Tampa, FL 33631-3370**

Fax: **1-877-277-1805**

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.

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