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:

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:

W9 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.: 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.*