missouricare
A WellCare Company

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

Provider Check Tracer Request Form

Please note that: Check tracer request should only be initiated after 45 days from the issue date.

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 on 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 e-mail at **ClaimsCorrespondence@wellcare.com**, 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.

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