CORRESPONDENCE COVER PAGE

- ***Note: Submission of this form constitutes agreement not to bill the participant***

This form is intended to be used for submission of additional documentation requested or required to process and/or adjust a previously processed claim. If you need to submit corrections to a previously submitted claim, **do not** use this form, please follow the "Corrected Claim submission" guidelines.

Please send this completed form and requested documentation to:
providers@welbehealth.com , or mail to
Attn: Claims Department WelbeHeath PO Box 30760, Tampa, FL 33630-3760

PROVIDER INFORMATION

Rendering Provider/Facility Name: NPI:
Pay To Affiliate Name: Contact Name:
Provider Billing Address: Phone #:
City/State: Zip Code:

PARTICIPANT INFORMATION

Participant Name: WelbeHealth ID #:
Participant Date of Birth: Patient Acct. #:

CLAIM INFORMATION (*Send one cover page per claim*)

Claim #: Service Date(s):
Service Type (*check only one*): ___ Inpatient ___ Outpatient ___ Professional ___ Dental
Appeal/PDR # (*if applicable*): Authorization # (*if applicable*):

Reason for documentation submission:

__ Claim/Claim line denial
__ Appeal/PDR Determination Letter
__ Authorization/MND Denial
__ Timely Filing

Requested documentation your attaching:

__ Check/Remittance Advice (RA)
__ Consent Form
__ Proof of timely filing
__ ER/Trauma Report/Notes
__ Invoice/MSRP/Itemized Statement
__ Medical Records
__ W-9 Form (signed)
__ Physician's Referral
__ Transportation Report
__ Other Supporting Documents (***please provide detail on what documentation is being submitted and why***)