Welbe Health

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 fax additional documentation with claim form to **(626) 498-2099**
ATTN: Corrs Unit

Must include the proper Correspondence form and documentation needed for review and processing.

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
PDR # (*if applicable*): Authorization # (*if applicable*):

Reason for documentation submission:

- ☐ Claim/Claim line denial
- ☐ PDR Determination Letter
- ☐ Authorization/MND Denial
- ☐ Timely Filing

Requested documentation your attaching:

- ☐ Check/Remittance Advice (RA)
- ☐ Proof of timely filing
- ☐ ER/Trauma Report/Notes
- ☐ Invoice/MSRP/Itemized Statement
- ☐ W-9 Form (signed)