



Provider Information Update Form

This form serves to capture non-participating provider information to efficiently adjudicate claims. Please complete all of the following steps:

1. Complete the form fields below.
2. Attach the claim and related information to the form.
3. Mail to: **Configuration: Non-Participating Provider Team** (*contact information is listed at the bottom of this page*)

Provider Name: _____	Federal Tax ID #: _____
Group Name: _____	Authorization #: _____
Physical Address: _____ _____	Medical License #: _____
Billing Address: _____ _____	Specialty: _____
Office Telephone #: _____	Medicaid #: _____
Fax #: _____	Medicare #: _____
Office Hours: _____	UPIN #: _____
Contact #: _____	NPI #: _____
Completed By: _____	NPI Effective Date: _____
	WellCare Member ID #: _____
	WellCare Member Name: _____

Mail this form along with the claim(s) to:

WellCare Health Plans, Inc.
Configuration: *Non-Participating Provider Team*
PO Box 31370
Tampa, FL 33631-3370

This information is confidential. This form and any attachments are intended for the exclusive use of the addressee(s) and may contain information that is proprietary, confidential and/or exempt from disclosure, and may be Protected Health Information. If you are not the intended recipient, please contact the sender and destroy all copies of this message.