Corrected Claim Form

Please mail completed form to:

Wellcare By Allwell
ATTN: Corrections, Reconsiderations or Appeals
PO Box 3060
Farmington, MO 63640-3822

Provider Name:	**Medicare Number and/or NPI Number:**
Claim Control Number:	**Date(s) of Services:**
Member Name:	**Member Number:**

Reason for Request:

☐ Other insurance payment - Explanation of Benefits (EOB) or Explanation of Payment (EOP) must be attached.

☐ Incorrect payment or other (please explain in Comments below):

Comments:

For Wellcare use only. Providers please do not complete the shaded areas:

Date Received:	**Date Due:**	**Reviewed By:**