

## Corrected Claim Form



**Please mail completed form to:**

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

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

**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):

<b>Comments:</b>
------------------

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

<b>Date Received:</b>	<b>Date Due:</b>	<b>Reviewed By:</b>
-----------------------	------------------	---------------------