WellCare®

TCN _____

Coordination of Benefits (COB) Notification Form

Member Name: _____ **Medicaid ID #:**_____

I. CO-PAYMENT NOTIFICATION

No EOB Available. Coverage is through _____ insurance/benefit plan. The co-payment for this service is _____.

II. COB NON-COVERAGE AFFIDAVIT

I submitted my claim(s) to on _____ on _____ for payment.
Insurance Carrier *Date*

After receiving no response, I contacted the carrier on _____ for confirmation.
Date

Insurance Representative:_____ Telephone: _____

Insurance was cancelled on _____.
Date

☐ Service is non-covered; annual/lifetime service limits exceeded.
☐ Member not covered under this policy.
☐ Out-of-Network Provider, No In-Network provider available to provide Medicaid covered services (explain below).
☐ Other (explain)

_____
_____
_____
_____

By signing, I certify that, to the best of my knowledge, the information above is verified and accurate, and that this notification form applies to any associated claim(s) and is made a part thereof.

_____ _____ _____
Signature of Patient Account Representative ***Date*** ***Provider #***

Attach this form to your claim(s) for paper claim submission, or if claim submitted electronically, indicate the associated TCN above and forward to WellCare for processing. Our mailing address is:
WellCare Health Plans, Attn: Claims Georgia, PO Box 31224, Tampa, FL 33631-3224.

III. COB INFORMATION UPDATE

When completing only this portion of the form, it may be mailed to ***WellCare Health Plans, Attn: Claims Georgia, PO Box 31224, Tampa, FL 33631-3224.*** If there are multiple cards, e.g., a medical card and a pharmacy card, complete separate forms or make copies of each card (front & back) to submit with this form. For questions, please contact our Provider Hotline at **866-231-1821**.

COB INFORMATION: *Please complete in full or attach a copy of the insurance card(s), front and back.*

Policyholder: _____ Patient Relationship to Policyholder: _____

Insurance Carrier: _____ Policy #: _____

Employer: _____ Group #: _____

Subscriber/Member ID #: _____ Effective Date: _____

Coverage Type(s): *(Check all that apply)*

☐ **HMO/PPO** ☐ **Major Medical** ☐ **Dental** ☐ **Vision** ☐ **Pharmacy** ☐ **Long Term Care**

Other (*Specify*): _____