DCN:
WCN:

DATE:

PROVIDER UPDATE FORM

If you have previously received and submitted this form for the specified provider, PLEASE DISREGARD.

Please complete the following information and fax this form to the below fax number. This information is needed in order to process your claim.

Provider's Name:
Group Name:
Physical Address:

Billing Address:

Office phone #:

Fax #:

Filed By:

Contact #

Federal Tax ID #:

Medical License #:
Specialty Type:

Medicaid #:
Medicare #:

NPI #:

Office hours:

WellCare Member ID #:

WellCare Member Name:

Fax # 877-849-5073