Provider Claim Payment Dispute Resolution Form

Request Date: ____________________

Provider Information

Name: ____________________

Address: ____________________

City/State/Zip: ____________________

Telephone: ____________________

Fax: ____________________

Contact Person: ____________________

Patient Information

(List multiple members on a separate sheet)

Name: ____________________

ID Number: ____________________

Date of Birth: ____________________

Service Provider Information

Date(s) of Service: ____________________ Place of Service: ____________________

Claims Number(s):

Explanation of Issue(s):

Fill out the form completely and keep a copy for your records. Send this form, within 1 year of the date of the remittance advice, with all documentation for your request to Well Care Health Plans, Inc. P.O. Box 4438, Scranton, PA 18505. You may also fax the request if less than 10 pages to 1-866-473-9122. Your request will be processed once all necessary documentation is received and you will be notified of the outcome. ***Failure to submit supporting documentation may delay our response to your request.**