Practice Name: _____

Practice Address: _____

Date: _____

Update Provider Demographics / Other Updates

This form authorizes Wellcare to load the list of providers below to the following:

Practice (Group) Name:		**Primary Location Address:**	
Group NPI:		**Tax ID:**	
Pay to (Vendor) Name & Address:		**Correspondence Address:**	

Provider Name	Provider ID	Effective Date	Medicaid?(Y/N)	Medicare?(Y/N)	Ambetter? (Y/N)

Attach roster if more than five providers need to be added.

Add Address ☐ PCP Status ☐ Update Name ☐

Close Panel ☐ Open Panel ☐ Update Specialty ☐

Add CLIA ☐ *Must submit copy of CLIA certificate with this letter if labs need to be loaded.

Other: ☐ _____

Specific Update Requested:

Requestor Name & Title: _____

Requestor Phone & Email: _____

Please email completed form to your Provider Relations Representative.