



Practice Name: _____

Practice Address: _____

Date: _____

Update Provider Demographics / Other Updates

This form authorizes WellCare of Kentucky 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.