

**Paper Remittance
Advice Request Form**



Date: _____

Please note: You must complete all data elements and print clearly – failure to do so may result in a delay.

Provider Demographics

Practice name

Practice TIN

Practice address

Requestor name and title

Requestor phone number

Please explain your need for receiving a Paper Remittance Advice:

Signature of requestor

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Advice Request Form**



***** HEALTH PLAN USE ONLY*****

Request reviewed and authorized by

(Manager, Provider Engagement MA)

Request reviewed and authorized by

(Director of Provider Engagement)

Mail or fax completed form to:

Massachusetts

WellSense Health Plan
Attention: Provider Engagement
Dept.
Schrafft's City Center
529 Main Street, Suite 500
Charlestown, MA 02129
Fax: 617-897-0849
Provider Services Center:
888-566-0008

New Hampshire

WellSense Health Plan
Attention: Provider Engagement
Dept.
1155 Elm Street
Manchester, NH 03101
Fax: 603-263-3055
Provider Service Center:
877-957-1300, option 3