BOSTON MEDICAL CENTER HEALTHNet PLAN

WELL SENSE HEALTH PLAN

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

***** 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:

BMC HealthNet 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

Well Sense Health Plan
Attention: Provider Engagement Dept.
1155 Elm Street
Manchester, NH 03101

Fax: 603-263-3055
Provider Service Center: 877-957-1300, option 3