PO Box 15369
Springfield, MA 01115-5369
(877) 657-5039
specialriskcs@wellfleetinsurance.com
Fax: (413) 733-4612

CLAIM FILING INSTRUCTIONS

Please note this is not a liability insurance policy. In order to file a claim for reimbursement, the following steps must be followed:

Notice of a claim must be provided within 90 days of injury or sickness covered by the policy. A completed Claim Form is required. Claim Forms not fully completed can cause Claim Representative to return Claim Form and cause processing delays.

Submitting the appropriate documentation is essential for timely adjudication of your claim expenses. If you are receiving treatment, please request an itemized bill (CMS 1500 form from a physician or a UB04 from hospital is preferred). All itemized bill(s) **must** include:

- Provider's name and address;
- Provider's Tax ID Number;
- Diagnosis Code (ICD-10);
- Date(s) of service;
- Types of service or procedure code;
- Provider charges for each procedure.

Please notify all healthcare providers that have or will be treating you and provide them with your insurance information and the following claims mailing address:
Wellfleet
Po Box 15369
Springfield MA 01115-5399

Also note that if you have other insurance, you must first submit the expenses to your Primary insurance. The primary insurance Explanation of Payment must be included with the itemized bill. If you do not have Primary insurance, then only the itemized bills are needed.

Please feel free to contact us at 877-657-5039 between the hours of 8:30am and 5:00pm ET with any questions.

Very truly yours,

Wellfleet