

Prescription Drug Direct Member Reimbursement Form

Instructions: Use this form when you paid full price for a covered prescription drug and you are asking us for a refund. Fill it out and send it to us. Be sure to add proof that you paid for the drug. (This could be the prescription label receipt(s) and cash/credit card receipts). You can ask your pharmacy to help with this. Important:

- **Forms without the needed information, that are not legible, or drug bill was not paid yet, may cause processing delay or denial**
- **Reimbursement is not guaranteed**

Please mail prescription label receipt(s), cash register receipts, and this completed form to:

WellCare Reimbursement Department
PO Box 31577
Tampa, FL 33631-3577

Please call us if you need help with this form. The Customer Service phone number is listed on the back of your member card.

Example Prescription Label

Below is a sample prescription label. Use this as a guide to find the information you need to complete this form. Each pharmacy has its own label format. Please ask your pharmacy to obtain any missing information.

ABC Pharmacy #1234 NPI: 1234567890 123 Any Road Tampa, FL 12345-6789	(813)555-1234 Date of Fill: 1/1/2008 Physician Name: Smith NPI: 1234567890
John Doe RX#: 1234567	
Take one (1) capsule by mouth three (3) times daily.	Copay: \$10.00
Amoxicillin 500mg capsules (Teva) 12345-6789-01	Quantity Dispensed: 30 Day Supply: 10 Refills Remaining: 1 Original Date: 1/1/2008

- | | |
|--|--|
| 1. Pharmacy NPI (National Provider Identification) | 6. Amount Paid |
| 2. Date of Fill | 7. Quantity Dispensed |
| 3. Physician Name | 8. Day Supply |
| 4. Physician NPI Number | 9. Drug Name |
| 5. Prescription (RX) Number | 10. NDC (National Drug Code for the drug filled) |

Who is making this request? Member Appointed Representative

Appointed Representatives:

- Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice

Complete the following section ONLY if the person making this request is not the member or prescriber:

Requestor's Name		
Requestor's Relationship to Member		
Address		
City	State	ZIP Code
Requestor Phone		

Representation documentation for requests made by someone other than member or the member's prescriber:

- **Attach documentation showing the authority to represent the member (a completed Authorization of Representation Form CMS-1696 or a written equivalent)**
- **For more information on appointing a representative, contact your plan or 1-800-Medicare**

Member Information

Member's Name:		
Member ID #:	Member Phone:	
Address:		
City:	State:	ZIP Code:

Reason for Request

<input type="checkbox"/> Drug received during hospital stay	<input type="checkbox"/> Copayment Discrepancy
<input type="checkbox"/> No Identification Card Available	<input type="checkbox"/> Pharmacy Unable to Process Claim Electronically
<input type="checkbox"/> Out of Network Pharmacy Used	<input type="checkbox"/> Vaccine
<input type="checkbox"/> Emergency – Please describe below	<input type="checkbox"/> Other – Please describe below

Clearly mark in this section the drug(s) you are asking for reimbursement. Only drugs listed in this section will be considered. Use more copies of this section of the form if you need more space. Dr. Name and NPI, please provide the physician information who prescribed the drug.

Requested Prescription Drug Information				
Drug Name	Date of Fill	Quantity	Day Supply	Amount Paid
NDC	Physician Name/NPI		Pharmacy NPI	RX#
Drug Name	Date of Fill	Quantity	Day Supply	Amount Paid
NDC	Physician Name/NPI		Pharmacy NPI	RX#
Drug Name	Date of Fill	Quantity	Day Supply	Amount Paid
NDC	Physician Name/NPI		Pharmacy NPI	RX#
Drug Name	Date of Fill	Quantity	Day Supply	Amount Paid
NDC	Physician Name/NPI		Pharmacy NPI	RX#
Drug Name	Date of Fill	Quantity	Day Supply	Amount Paid
NDC	Physician Name/NPI		Pharmacy NPI	RX#

I certify that the prescription(s) referred to above have been received and information stated is accurate. I certify that the patient for whom this claim is made is a covered person and that the prescription is for the sole use of the named patient. I release all information pertaining to the above claim(s) to the plan administrator, underwriter, sponsored policy holder and/or any person or entity acting on behalf of the patient at their request.

Enrollee Signature*: _____ **Date:** _____

*If the individual cannot sign, a person who is authorized to do so under state law in the state where the individual resides must sign above. This signature certifies that the person signing is authorized under state law to complete this form and that all documentation of this authority is available upon request by the plan from the individual state Medicaid agency or by the Centers for Medicare & Medicaid Services, the federal agency that runs Medicare.

WellCare Health Plans, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-877-374-4056** (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-374-4056** (TTY: **711**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-374-4056** (TTY: **711**)。