Member Medical Reimbursement Claim Form

Use this claim form to be reimbursed for eligible out-of-pocket **medical** expenses. EMAIL form and required documents to: **MemberReimbursements@Wellcare.com,** OR **FAX** form and required documents to: **1-813-283-3284,** OR **MAIL** form and required documents to: Wellcare By 'Ohana Reimbursement Department • P.O. Box 31381 • Tampa, FL 33631-3381. Please submit one form per member.

IMPORTANT NOTE: Use this form when requesting reimbursement for **MEDICAL** services only. This form is **NOT** to be used for Pharmacy Reimbursements. Please contact your Benefit Administrator or Member Services if the request is for Pharmacy, Part D, routine Dental, Hearing, Transportation, Vision, Fitness or Flex card services. The contact information is on the back of your ID card.

For the reimbursement of Medical Services, FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. Completion of this form.

- Print your name and Member ID number as shown on your Wellcare By 'Ohana ID Card.
- Provide your mailing address and include your telephone number.
- Describe why you are requesting reimbursement.
- Provide the date of service for which you are requesting reimbursement. (This is the date the service was rendered.) List separately each date of service or admission date for inpatient/hospital stays.
- Print the name of the doctor or facility that provided the service.
- Provide a brief description of the service that was provided.
- List the amount requested for the individual service line.
- Add all individual lines together and provide the total amount requested for the reimbursement of all services.

B. Each itemized bill MUST include all the following information:

- Date of each service
- Place of each service – Doctor's Office, Independent Laboratory, Outpatient Hospital, Inpatient Hospital, Nursing Home, Patient's Home
- Description of each surgical or medical service or supply furnished
- Charge for EACH service
- Doctor's or supplier's name and address. Many times, a bill will show the names of several doctors or suppliers. IT IS VERY IMPORTANT THAT YOU IDENTIFY THE ONE WHO TREATED YOU. Simply circle their name on the bill.

C. Proof of Payment documentation:

- Copy of canceled check (front and back)
- Credit card statement showing provider as paid
- Invoice/statement from provider showing provider's name, address, telephone number, date(s) of service, services rendered and balance marked paid with method of payment – cash, check or credit card

Member Name _____ Member ID _____

Address _____ Telephone: _____

City _____ State _____ ZIP Code: _____

Please provide a brief description of your request:

Date of Service	Provider Name	Description of Service	Amount Requested

Total Amount of Reimbursement Request_____

I attest that the above information is true and accurate and that the services were received and paid for in the amount indicated above. I acknowledge that if any information on this form is misleading or fraudulent, I may be subject to criminal and/or civil penalties for submitting false health care claims.

Printed Name: _____ Signature: _____
Date: _____

Wellcare By 'Ohana will review your request for reimbursement after you complete this form and attach an itemized bill and payment receipt from your doctor or supplier. All requests will be processed within 60 days of receipt. Please note, your bill must be paid in full **before** you can submit this request for reimbursement and all required documentation must be included with the request. EMAIL form and required documents to: **MemberReimbursements@Wellcare.com,** OR **FAX** form and required documents to: **1-813-283-3284,** OR **MAIL** form and required documents to: Wellcare By 'Ohana Reimbursement Department • P.O. Box 31381 • Tampa, FL 33631-3381.

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.

Please contact your plan for details.