



## Member Medical Reimbursement Claim Form

**FAX** form and required documents to **1-813-283-3284** OR  
**MAIL** to WellCare Member Reimbursement Department • P.O. Box 31370 • Tampa, FL 33631  
 Use this claim form to be reimbursed for eligible out-of-pocket medical expenses.  
 Please submit one form per member.

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: \_\_\_\_\_

# HOW TO FILL OUT THIS FORM

## FOLLOW THESE INSTRUCTIONS CAREFULLY:

### A. Completion of this form.

- Print your name as shown on your WellCare ID Card.
- Print your Member ID number.
- 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. (If this request is for travel reimbursement, include the total mileage.)
- 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 of the following information:

- Date of each service
- Place of each service
  - Doctor's Office
  - Nursing Home
  - Independent Laboratory
  - Patient's Home
  - Outpatient Hospital
  - Inpatient Hospital
- 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 his/her 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

WellCare 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. Mail your completed form/documents to PO Box 31370, Tampa, FL 33631 or fax to **813-283-3284**.