REFUND CHECK INFORMATION SHEET*(RCIS)

NOTE: Form must be completed in full, and used only when submitting one (1) refund check per claim. <u>Not</u> to be used for multiple claims.
****RCIS Form should be placed behind refund check when submitting.***

*REFUND CHECK #*_____

CHECK DATE _____

MEMBER NAME _____

PATIENT ACCT # _____

WELLCARE CLAIM # _____

DOS _____

TOTAL BILLED AMOUNT OF CLAIM _____

AMOUNT BEING REFUNDED FOR THIS CLAIM _____

REASON FOR REFUND _____

_____

_____

*ADDITIONAL INFORMATION REQUIRED FOR POSTING*_____

_____

CONTACT NAME/PHONE/EMAIL _____

_____

Recovery Dept. Mailing Address:
WellCare Health Plans
P.O. Box 31584 Tampa, Florida 33631-3584