WellCare Direct Member Reimbursement Form

Use this form when you pay full price for a covered prescription drug. Complete the form and send it to us to ask to be reimbursed. Send the original prescription label receipt(s) with this form. Cash register and credit card receipts alone are not acceptable as proof of purchase. Forms without the required information can not be processed. Reimbursement is not guaranteed.

Member Information

Name: _____ Date of Birth: _____ ID Number: _____

Street Address: _____ Apt/Unit #: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____ Client ID: 8257

Reason for Request

☐ No Identification Card Available	☐ Copayment Inquiry
☐ Out of Network Pharmacy Used	☐ Pharmacy Unable to Process Claim Electronically
☐ Emergency – Please Describe	☐ Other – Please describe

Pharmacy/Prescription Information

Please attach detailed prescription label receipts. Or you can ask your pharmacist to complete the remaining information. See page 2 of this form for more space.

We must have this information to process your claim.

Drug Name	*Date of Fill*	*Quantity*	*Day Supply*	*Amount Paid*
NDC	*Dr. Name*	*Dr. NPI*	*Pharmacy NPI*	*RX#*

Special Instructions:

We must be able to clearly read the information on the prescription label receipt, or your claim may be delayed or denied.

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

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

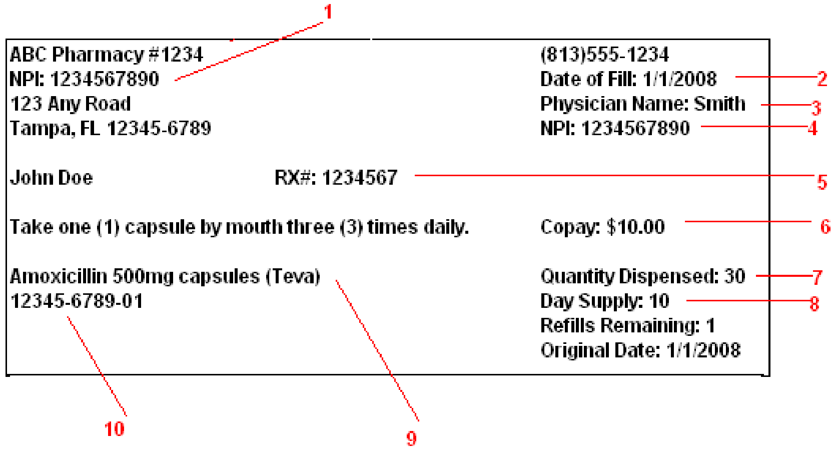
I certify that the prescription(s) referred to above have been received and information stated is accurate. I certify that the patient for whom this claim is made is a covered person and that the prescription is for the sole use of the named patient. I release all information pertaining to the above 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.

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 contact your pharmacy to obtain any missing information.



1. Pharmacy NPI
2. Date of Fill
3. Physician Name
4. Physician NPI Number
5. Prescription (RX) Number
6. Amount Paid
7. Quantity Dispensed
8. Day Supply
9. Drug Name
10. NDC

Pharmacy/Prescription Information (Continued from Page 1)

Drug Name	*Date of Fill*	*Quantity*	*Day Supply*	*Amount Paid*
NDC	*Dr. Name*	*Dr. NPI*	*Pharmacy NPI*	*RX#*
Drug Name	*Date of Fill*	*Quantity*	*Day Supply*	*Amount Paid*
NDC	*Dr. Name*	*Dr. NPI*	*Pharmacy NPI*	*RX#*
Drug Name	*Date of Fill*	*Quantity*	*Day Supply*	*Amount Paid*
NDC	*Dr. Name*	*Dr. NPI*	*Pharmacy NPI*	*RX#*
Drug Name	*Date of Fill*	*Quantity*	*Day Supply*	*Amount Paid*
NDC	*Dr. Name*	*Dr. NPI*	*Pharmacy NPI*	*RX#*

If you need help with this form, please call us. Call the Customer Service phone number listed on the back of your membership card.

WellCare is a Medicare-approved Part D sponsor.

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