

HealthStuff™ (Over-the-Counter) Items Reimbursement Form
 For WellCare Access (HMO), WellCare Advocate Complete (HMO), WellCare Liberty (HMO),
 WellCare Select (HMOPOS) or WellCare Select (HMO) Plans Only

FAX form and receipt to 1-877-849-5068

OR

MAIL form and receipt to WellCare OTC DMR Center • P.O. Box 31396 • Tampa, FL 33631-3396

Use this claim form for eligible *over-the-counter items* (reimbursements only). Please submit one reimbursement form per member.

Member Name: _____ Member ID: _____

Check here if new address

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: () _____

Receipts must be submitted within 90 days of receipt date and are processed within 30 days of receipt.

Date Purchased	Name of Retailer	Name/Description of Item(s) Purchased	Item Amount (A)*	Tax Amount (If Applicable) (B)*	Total Claim Amount (Add Amount A and B)*
1. _____	_____	_____	\$ _____	\$ _____	\$ _____
2. _____	_____	_____	\$ _____	\$ _____	\$ _____
3. _____	_____	_____	\$ _____	\$ _____	\$ _____
4. _____	_____	_____	\$ _____	\$ _____	\$ _____

*See sample claim submission on next page.

Total claim amount should include tax for each item.

Grand Total: \$ _____ \$ _____ \$ _____



By signing this form, I confirm that the request for reimbursement is for eligible over-the-counter items and is not covered by any other plan or program. (If you have questions regarding eligible items, please refer to your HealthStuff™ catalog or call Customer Service.)

Member's Signature: _____ Date: _____

Remember:

Complete the claim form (page 1).

Also include receipt for item(s) purchased.

Your receipt must include the date of purchase and item(s) purchased.

You may fax or mail your claim form and receipt, **but faxing provides faster customer service.**

Fax your form and receipt to: WellCare OTC DMR Center at 1-877-849-5068

OR

Mail your form and receipt to: WellCare OTC DMR Center • P.O. Box 31396 • Tampa, FL 33631-3396

To get more information or to request additional claim forms, please contact Customer Service at one of the toll-free numbers listed below:

Connecticut: 1-866-635-7047 • Florida: 1-866-637-8041 • Louisiana: 1-866-530-9488 • New Jersey: 1-866-530-9496

New York: 1-866-482-3363 • New York Advocate Complete: 1-866-661-1232 • New York Liberty: 1-866-491-5746 • Ohio: 1-866-530-9487

For all states: TTY/TDD: 1-877-247-6272 • Monday–Sunday, 8am to 9pm Eastern. Or visit us at www.wellcare.com.

SAMPLE RECEIPT

#09396

Green Pharmacy

08/13/09

Pain Reliever	\$10.00 (A)
Cough Syrup	\$10.00 (A)
Candy	\$6.00

SUBTOTAL	\$26.00
TAX (7%)	\$1.82 (B)
TOTAL	\$27.82

SAMPLE CLAIM SUBMISSION

Date Purchased	Name of Retailer	Name/Description of Item(s) Purchased	Item Amount (A)	Tax Amount (If Applicable) (B)	Total Claim Amount (Add Amount A and B)
1. <u>8/13/09</u>	<u>Green Pharmacy</u>	<u>Pain Reliever</u>	\$ <u>10.00</u>	\$ <u>0.70</u>	\$ <u>10.70</u>
2. <u>8/13/09</u>	<u>Green Pharmacy</u>	<u>Cough Syrup</u>	\$ <u>10.00</u>	\$ <u>0.70</u>	\$ <u>10.70</u>
Grand Total:			\$ <u>20.00</u>	\$ <u>1.40</u>	\$ <u>21.40</u>