Member Medical Reimbursement Claim Form

FAX form and any 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 healthcare claims.

Printed Name: _____ Signature:_____ Date:_____

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HOW TO FILL OUT THIS FORM

FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. Completion of this form.

- Print your name like it is on your Staywell ID Card.
- Print your Member ID number.
- Print your mailing address and telephone number.
- Tell us why you seek reimbursement.
- Give us the date of service for which you seek reimbursement. (This is the date you got the service.) List separately each date of service or admission date for inpatient/hospital stays.
- Print the name of the doctor or facility that gave you the service.
- Tell us about the service that was provided. (Was this for travel ? Add mileage.)
- State the amount you seek for the individual service line.
- Add all individual lines together and state the total amount you seek.

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

- Date of each service
- Place of each service

Doctor's Office	**Independent Laboratory**	**Outpatient Hospital**
Nursing Home	**Patient's Home**	**Inpatient Hospital**

- Description of each surgical or medical service or supply given
- 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. **Please note:** IT IS VERY IMPORTANT THAT YOU IDENTIFY THE ONE WHO TREATED YOU. Just circle the name on the bill.

C. Proof of Payment documentation:

- Copy of canceled check (front and back)
- Credit card statement showing payment to provider
- Invoice/statement from provider showing provider's name, address, telephone number, date(s) of service, services provided 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. Please 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. 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**. If you have, any questions please call <Staywell Health Plans> at **<1-866-334-7927>,** Monday –Friday from 8 a.m. to 7 p.m.

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