P.O. Box 31577
Tampa, FL 33631-3577

Prescription Drug Direct Member Reimbursement Form

Instructions: Use this form when you paid full price for a covered prescription drug and you are asking us for a refund. Fill it out and send it to us. Be sure to add proof that you paid for the drug. (This could be the prescription label receipt(s) and cash/credit card receipts). You can ask your pharmacy to help with this. Important:

- **Forms without the needed information, that are not legible, or drug bill was not paid yet, may cause processing delay or denial**
- **Reimbursement is not guaranteed**

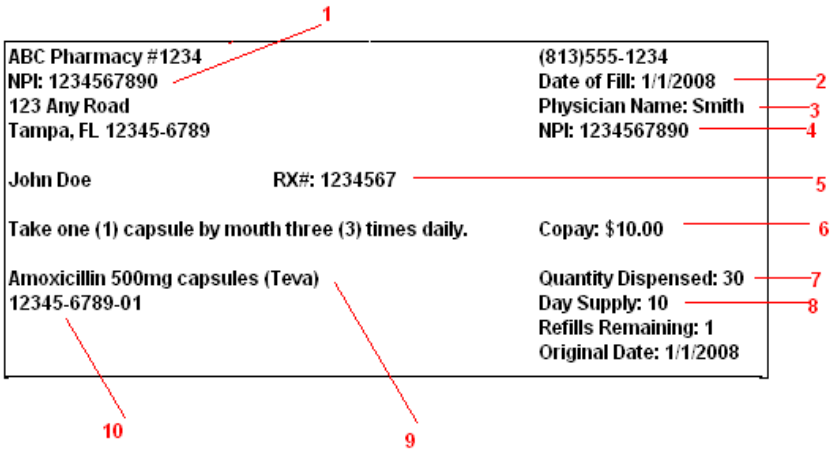
Please mail prescription label receipt(s), cash register receipts, and this completed form to:

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

Please call us if you need help with this form. The Customer Service phone number is listed on the back of your member card.

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 ask your pharmacy to obtain any missing information.



1. **Pharmacy NPI (National Provider Identification)**
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 (National Drug Code for the drug filled)**

Who is making this request? Member ☐ Appointed Representative ☐

***Appointed Representatives*:**

- Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice

Complete the following section ONLY if the person making this request is not the member or prescriber:

Requestor's Name		
Requestor's Relationship to Member		
Address		
City	State	ZIP Code
Requestor Phone		

<u>Representation documentation for requests made by someone other than member or the member's prescriber:</u>

- **Attach documentation showing the authority to represent the member (a completed Authorization of Representation Form CMS-1696 or a written equivalent)**
- **For more information on appointing a representative, contact your plan or 1-800-Medicare**

Member Information

Member's Name:		
Member ID #:	Member Phone:	
Address:		
City:	State:	ZIP Code:

Reason for Request

☐	Drug received during hospital stay	☐	Copayment Discrepancy
☐	No Identification Card Available	☐	Pharmacy Unable to Process Claim Electronically
☐	Out of Network Pharmacy Used	☐	Vaccine
☐	Emergency – Please describe below	☐	Other – Please describe below

_____
_____
_____
_____
_____
_____

Clearly mark in this section the drug(s) you are asking for reimbursement. Only drugs listed in this section will be considered. Use more copies of this section of the form if you need more space. Dr. Name and NPI, please provide the physician information who prescribed the drug.

Requested Prescription Drug Information				
Drug Name	**Date of Fill**	**Quantity**	**Day Supply**	**Amount Paid**
NDC	**Physician Name/NPI**		**Pharmacy NPI**	**RX#**
Drug Name	**Date of Fill**	**Quantity**	**Day Supply**	**Amount Paid**
NDC	**Physician Name/NPI**		**Pharmacy NPI**	**RX#**
Drug Name	**Date of Fill**	**Quantity**	**Day Supply**	**Amount Paid**
NDC	**Physician Name/NPI**		**Pharmacy NPI**	**RX#**
Drug Name	**Date of Fill**	**Quantity**	**Day Supply**	**Amount Paid**
NDC	**Physician Name/NPI**		**Pharmacy NPI**	**RX#**
Drug Name	**Date of Fill**	**Quantity**	**Day Supply**	**Amount Paid**
NDC	**Physician Name/NPI**		**Pharmacy NPI**	**RX#**

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.

‘Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.

WellCare Health Plans, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-877-374-4056** (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-374-4056** (TTY: **711**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-374-4056** (TTY: **711**)。