REFUND CHECK INFORMATION SHEET*(RCIS)

NOTE: Form must be completed in full, and used only when submitting 1 refund check per claim. Not 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