‘Ohana Health Plan Direct Member Reimbursement Form

Use this form if you pay for a covered prescription drug at retail cost and want to be repaid. **Fill out the form. Send it to the address below. Also send the original prescription label and receipt(s).** We do not accept cash and credit card receipts alone as proof of purchase. **Claim forms that do not have all information will not be processed. Repayment is not guaranteed.**

Member Information

Name: ______________________ Date of Birth: ______________ ID Number: ____________

Street Address: ______________________ Apt/Unit #: __________ Phone #: ______________

City: __________________________ State: ________ ZIP Code: ____________ Client ID: 6257

Reason for Request

☐ No Identification Card Available	☐ Co-payment 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 ask your **pharmacist** to fill out the information below. **See page two 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. DEA/NPI*	*Pharmacy NPI*	*RX Number*

Special Instructions:

We must be able to read the prescription label receipt. If we cannot, repayment may take longer or be denied. Please mail prescription label receipt(s), cash register receipt(s) and this completed form to:

‘Ohana Health Plan
Reimbursement Department
P.O. Box 31577
Tampa, FL 33631-3577

I confirm the following about the items listed on this form. The prescription(s) have been received. The information is correct. The patient listed is a covered person. The drug is for the use of that patient. The information about the claim(s) may be released. It can be given to these people:

- plan administrator
- underwriter
- sponsored policy holder
- anyone acting for the patient at their request

Member Signature*: ______________________________Date: __________________

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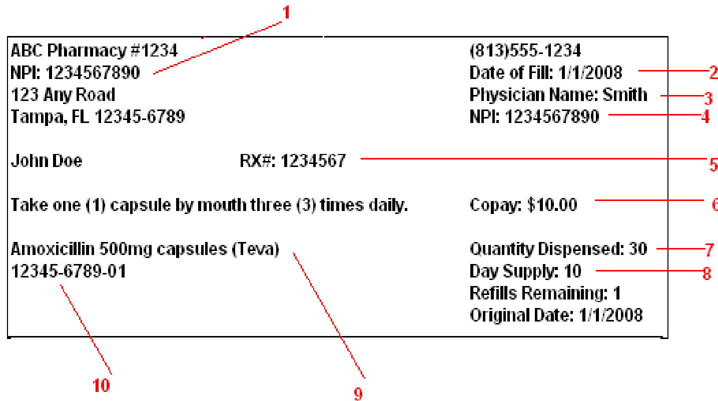
*Is the enrollee not able to sign? Then another person must sign. He or she must be approved to sign under the laws of the state where the enrollee lives. This signature means that the person who signs is approved under state law to fill out this form. It also confirms that proof of this is available if it is asked for. This request can be from the plan or from the state Medicaid agency. It can also be from the Centers for Medicare & Medicaid Services (CMS). CMS is the federal agency that runs Medicare.

__Sample Prescription Label__

The label below is a sample. Use it as a guide. It can help you find the information you need. Each pharmacy has its own type of label. Please contact your pharmacy to get help with any missing information. Do you need help completing this form? Please contact us. Call the Customer Service phone number listed on the back of your member ID card.



1. Pharmacy NPI Number
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)				
NDC	*Dr. Name*	*Dr. DEA/NPI*	*Pharmacy NPI*	*RX Number*
Drug Name	*Date of Fill*	*Quantity*	*Day Supply*	*Amount Paid*
NDC	*Dr. Name*	*Dr. DEA/NPI*	*Pharmacy NPI*	*RX Number*
Drug Name	*Date of Fill*	*Quantity*	*Day Supply*	*Amount Paid*
NDC	*Dr. Name*	*Dr. DEA/NPI*	*Pharmacy NPI*	*RX Number*

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.
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OH15-052 Pharmacy DMR Form 60532

This document has important information from ‘Ohana Health Plan. You can request this written document to be provided to you only in Ilocano, Vietnamese, Chinese (Traditional) and Korean. If you need it in another language you can request to have it read to you in any language. There is no charge. We also offer large print, braille, sign language and audio. Call us toll-free at 1-888-846-4262. (TTY/TDD: 1-877-247-6272).

Daytoy a dokumento ket naglaon iti napateg nga impormasyon manipud iti ‘Ohana Health Plan. Mabalinyo a kiddawen a maisurat daytoy a dokumento iti Ilocano. Awan ti bayadanyo. Mabalinyo a kiddawen a maibasa daytoy kadakayo. Idiaya mi pay ti dadakkel a letra, braille, senyas a pagsasao ken audio. Tawagandakami iti awan-bayadna nga 1-888-846-4262. (TTY/TDD: 1-877-247-6272).

Tài liệu này có thông tin quan trọng từ chương trình bảo hiểm 'Ohana Health Plan'. Quý vị có thể hỏi xin tài liệu này viết bằng Tiếng Việt. Không tốn tiền. Nó có thể đọc lên cho quý vị. Chúng tôi cũng cung ứng bản in chữ lớn, chữ nổi braille cho người mù, ngôn ngữ sign language ra dấu và audio âm thanh. Xin gọi điện thoại chúng tôi số miễn phí 1-888-846-4262. (TTY/TDD: 1-877-247-6272).

這份文件有來自於 ‘Ohana Health Plan 的重要資訊。您可以要求用中文寫的該文件。沒有費用。 您可以讓人把此文件讀給您聽。我們還提供大字體、盲文、手語和音頻文件。請撥打免費電話 1-888-846-4262 (TTY/TDD： 1-877-247-6272) 聯繫我們。

이 문서에는 ‘Ohana Health Plan에 관한 중요 정보가 포함되어 있습니다. 이 문서는 한국어로도 요청하실 수 있습니다. 이는 무료 서비스입니다. 읽어주기 서비스도 가능하며. 큰 글씨, 점자, 수화 및 오디오로도 제공됩니다. 무료 전화 1-888-846-4262번으로 문의해 주십시오. (TTY/TDD: 1-877-247-6272).

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