Non-claim Remit Cost Share Collection Form

Please use this form if you are a Foster Home, Expanded Adult Residential Care Home or Nursing Facility that has collected cost share from a member, in situations where **cost share exceeds claim amount**. It may also be used to remit cost share where the member is a Medicare or other insurance primary, so there may be no Medicaid claim.

Please provide the information below. Also, include a check (payable to 'Ohana Health Plan) for the remaining monthly cost share. For more details, please contact our customer service department at (888) 846-4262.

Provider Name		Provider Number:
Provider Phone Number	**Contact Person (if different than Provider Name)**	
Member Name:		**Member ID Number:**
***Cost ShareMonth/Year** (Date of cost share month)	**Total Cost Share** (Monthly cost share determine by the state)	**Cost Share Amt. on claim**
Check amount paid to 'Ohana should be the total monthly member cost share (-) cost share amt. on claim (=) Check amount paid to 'Ohana	**Check #**	**Check amount paid to 'Ohana**

Please mail this form and your payment to:

WELLCARE
P.O. BOX 75510
CHICAGO, IL 60675-5510

* Please submit one form per member per month of cost share owed

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a Health Plan Members)
collection form.doc

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