WellCare HARMONY℠ A WellCare Company

WellCare/Harmony 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 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 three of this form for more space. We must have this information to process your claim. The Sample Prescription Label on the next page can show you where to find this information.

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:

WellCare/Harmony
Reimbursement Department
P.O. Box 31577
Tampa, FL 33631-3577

I confirm the following about the items listed on this form:

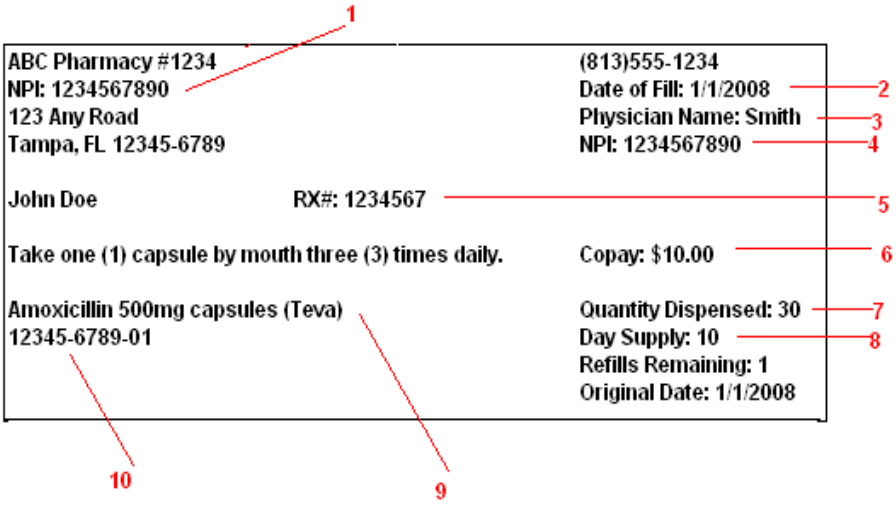
- The prescription(s) have been received.
- The information is correct.
- The patient listed is a covered person.
- The drug is for the use of that patient.
- The information about the claim(s) may be released. It can be given to these people:
    - o plan administrator
    - o underwriter
    - o sponsored policy holder
    - o anyone acting for the patient at their request

Enrollee Signature*: _____Date: _____

*Is the enrollee not able to sign? Then another person must sign. He or she must be approved to sign under the laws of Illinois. 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 and Medicaid.

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.



1. Pharmacy NPI
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)

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

Do you need help completing this form? Please contact us. Call Member Services at 1-800-608-8158. Para solicitar este documento en español o para escuchar la traducción, llame al Servicio al Cliente al 1-800-608-8158 (TTY 1-877-650-0952).