RECIPIENT CHOICE OF RESTRICTED SERVICES
(LOCK-IN) PROVIDER AGREEMENT

(1) Recipient name (2) Recipient ID Number	**REQUIRED CATEGORY – (supplied by WellCare of Nebraska, Inc. (commonly known as WellCare of Nebraska) and circled below)**
(3) Address (4) City or Town (4) State ZIP Code	(5) 1 One Pharmacy 2 One Pharmacy and One Primary Physician 3 One Pharmacy, One Primary Physician and One Hospital 4 One Pharmacy and One Prescribing Physician 9 All Medical Services

I, _____ Recipient ID Number _____
(6) (7)

Do hereby select the following as my choice of medical provider(s)
(Select **only** those indicated for the assigned lock-in category)

(8) (9)

☐ Pharmacy	Name Address
☐ Primary Physician	Name Address
☐ Hospital	Name Address
☐ Prescribing Physician	Name Address

I understand that, as of this date, any medical services provided by providers other than the above will be my own personal financial responsibility.

Signed _____
(10)

Witnessed _____
(11)

Date _____
(12)

☐ Original Selection (14)

☐ Change of Provider(s) Effective Date _____

Reason for change: _____
(13)

Instructions on Reverse Side

Item 1-4 Information may be entered by the Recipient or a health care provider.

Item 5 Required category will be determined by the WellCare Restricted Services Review Committee and circled on the form by WellCare prior to delivery to member.

Code	Category
1	One Pharmacy

You must select one pharmacy. WellCare will approve payment for prescriptions only to the pharmacy you select.

Code	Category
2	One Pharmacy and One Primary Physician

You must select one pharmacy and one primary physician. WellCare will approve payment to the pharmacy and primary physician you select.

Code	Category
3	One Pharmacy, One Primary Physician and One Hospital

You must select one pharmacy, one primary physician and one hospital. WellCare will approve payment only to the pharmacy, primary physician and hospital you select.

Code	Category
4	One Pharmacy and One Prescribing Physician

You must select one pharmacy and one prescribing physician. WellCare will approve payment for prescriptions only to the pharmacy you select. You may visit other physicians, but all prescriptions must be authorized by the prescribing physician you select.

Code	Category
9	All Medical Services

You must select one provider for each type of service you expect to receive. All types of medical services are included, and WellCare will approve payment only to the providers you select.

Item 6 Enter member name

Item 7 Enter member ID from WellCare ID card

Item 8-9 Name and Address of Provider(s) selected by the Recipient may be entered by the Recipient or a health care provider.

Item 10 Recipient **must** sign the agreement.

Item 11 The person that witnesses the Recipient's signature **must** sign. The witness **must** verify the Recipient's identity and be a health care representative (provider, pharmacist or supporting staff member) or a WellCare representative.

Item 12 Date of signing may be completed by either the Recipient or the Witness.

Item 13 May be completed by the Recipient or health care provider

Changes will be effective the first day of the following month, unless a different date is requested, the reason is documented and the date is approved by the WellCare Restricted Services Review Committee.

Return form via fax to WellCare **1-855-245-9151**
Or mail to WellCare Care Management, 10040 Regency Circle #100 Omaha, NE 68114