WellCare of New York, Inc.

WellCare of New York 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.**

[redacted]

Name: _____ **Date of Birth:** _____ **ID Number:** _____

Street Address: _____ **Apt/Unit #:** _____ **Phone #:** _____

City: _____ **State:** _____ **ZIP Code:** _____ **Client ID:** 6257

[redacted]

☐ 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:

WellCare of New York, Inc.
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

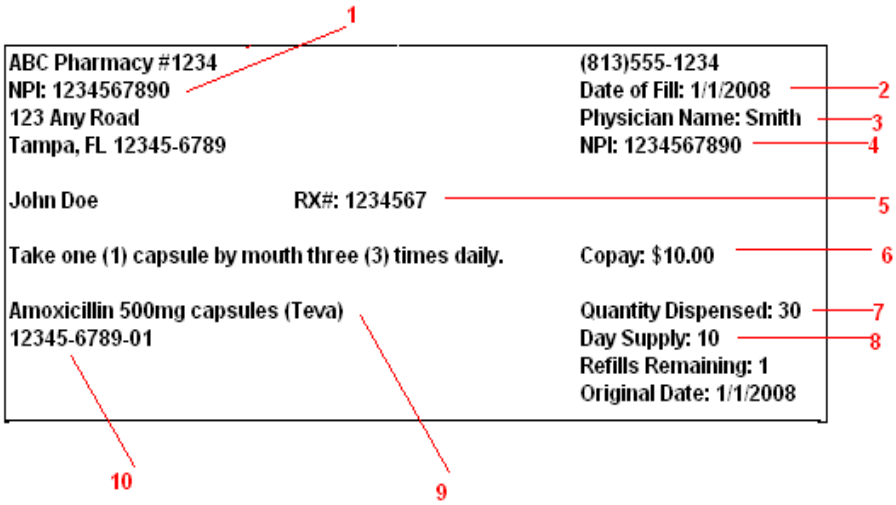
Enrollee Signature*: _____Date: _____

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



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**

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 the Customer Service phone number listed on the back of your member ID card.

If you have questions about this information, please call Member Services at 1-800-288-5441 (TTY/TDD1-877-247-6272).

Si usted tiene preguntas acerca de esta información, por favor llame a Servicio a Miembros al 1-800-288-5441 (TTY/TDD 1-877-247-6272).

如果您對此有任何問題，請向我公司客戶服務部詢問，電話是1-800-288-5441，

聽力/語言障礙者專用電話(TTY/TDD)是1-877-247-6272。

Со всеми дополнительными вопросами звоните, пожалуйста, в Отдел обслуживания по бесплатному телефону 1-800-288-5441 телефон с текстовым дисплеем для лиц с дефектами слуха 1-877-247-6272).