



REFUND CHECK INFORMATION SHEET*(RCIS)

NOTE: Form must be completed in full, and used only when submitting 1 refund check per claim. Not to be used for multiple claims.

***RCIS Form should be placed behind refund check when submitting.**

REFUND CHECK # _____

CHECK DATE _____

MEMBER NAME _____

PATIENT ACCT # _____

WELLCARE CLAIM # _____

DOS _____

TOTAL BILLED AMOUNT OF CLAIM _____

AMOUNT BEING REFUNDED FOR THIS CLAIM _____

REASON FOR REFUND _____

ADDITIONAL INFORMATION REQUIRED FOR POSTING _____

CONTACT NAME/PHONE/EMAIL _____

**Recovery Dept. Mailing Address:
WellCare Health Plans
P.O. Box 31584 Tampa, Florida 33631-3584**