



**WellCare of Ohio 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**

<input type="checkbox"/> No Identification Card Available	<input type="checkbox"/> Co-payment Inquiry
<input type="checkbox"/> Out-of-Network Pharmacy Used	<input type="checkbox"/> Pharmacy Unable to Process Claim Electronically
<input type="checkbox"/> Emergency – Please Describe	<input type="checkbox"/> 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.

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

**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 Ohio, 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.

ABC Pharmacy #1234 NPI: 1234567890 123 Any Road Tampa, FL 12345-6789	(813)555-1234 Date of Fill: 1/1/2008 Physician Name: Smith NPI: 1234567890
John Doe RX#: 1234567	
Take one (1) capsule by mouth three (3) times daily.	Copay: \$10.00
Amoxicillin 500mg capsules (Teva) 12345-6789-01	Quantity Dispensed: 30 Day Supply: 10 Refills Remaining: 1 Original Date: 1/1/2008

- |                             |                       |
|-----------------------------|-----------------------|
| 1. Pharmacy NPI             | 6. Amount Paid        |
| 2. Date of Fill             | 7. Quantity Dispensed |
| 3. Physician Name           | 8. Day Supply         |
| 4. Physician NPI Number     | 9. Drug Name          |
| 5. Prescription (RX) Number | 10. NDC               |

**Pharmacy/Prescription Information (Continued from Page 1)**

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

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.

Para solicitar este documento en español o para escuchar la traducción, llame al Servicio al Cliente al 1-800-951-7719 (TTY/TDD: 1-877-247-6272).