WellCare
Beyond Healthcare. A Better You.

Member Medical Reimbursement Claim Form

Please fully complete in black or blue ink and return this form along with copies of your Via mail: Premier Eye Care Attn: Member Services 6501 Park of Commerce Blvd, Suite 100 Boca Raton, Florida 33487 Questions?: Call Member Services at 1 (800) 738-1889	receipts & any other supporting documentation to: Via fax: 1 (800) 523-3788 Via Email: claimsinq@premiereyecare.net and please copy claimsteamleadership@premiereyecare.net Thank you!

Member Name _____ Member ID # _____

Address _____ Telephone: _____

City _____ State _____ ZIP Code: _____

Please provide a brief description of your request:

Date of Service	Provider Name	Description of Service	Amount Requested

Total Amount of Reimbursement Request _____

I attest that the above information is true and accurate and that the services were received and paid for in the amount indicated above. I acknowledge that if any information on this form is misleading or fraudulent, I may be subject to criminal and/or civil penalties for submitting fals e health care claims.

Printed Name: _____ Signature: _____ Date: _____

HOW TO FILL OUT THIS FORM

FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. Completion of this form.

- Print your name as shown on your WellCare ID Card.
- Print your Member ID number.
- Provide your mailing address and include your telephone number.
- Describe why you are requesting reimbursement.
- Provide the date of service for which you are requesting reimbursement. (This is the date the service was rendered.) List separately each date of service or admission date for inpatient/hospital stays.
- Print the name of the doctor or facility that provided the service.
- Provide a brief description of the service that was provided. (If this request is for travel reimbursement, include the total mileage.)
- List the amount requested for the individual service line.
- Add all individual lines together and provide the total amount requested for the reimbursement of all services.

B. Each itemized bill MUST include all of the following information:

- Date of each service
- Place of each service

Doctor's Office	Independent Laboratory	Outpatient Hospital
Nursing Home	Patient's Home	Inpatient Hospital

- Description of each surgical or medical service or supply furnished
- Charge for EACH service
- Doctor's or supplier's name and address. Many times a bill will show the names of several doctors or suppliers. IT IS VERY IMPORTANT THAT YOU IDENTIFY THE ONE WHO TREATED YOU. Simply circle his/her name on the bill.

C. Proof of Payment documentation:

- Copy of canceled check (front and back)
- Credit card statement showing provider as paid
- Invoice/statement from provider showing provider's name, address, telephone number, date(s) of service, services rendered and balance marked paid with method of payment – cash, check or credit card

WellCare will review your request for reimbursement after you complete this form and attach an itemized bill and payment receipt from your doctor or supplier. All requests will be processed within 60 days of receipt. Please note, your bill must be paid in full **before** you can submit this request for reimbursement and all required documentation must be included with the request. Mail your completed form/documents to fax: Member Services 1-800-523-3788.