WellCare®
Beyond Healthcare. A Better You.
P.O. Box 31577
Tampa, FL 33631-3577

Prescription Drug Direct Member Reimbursement Form

Instructions: Use this form when you paid full price for a covered prescription drug and you are asking us for a refund. Fill it out and send it to us. Be sure to add proof that you paid for the drug. (This could be the prescription label receipt(s) and cash/credit card receipts). You can ask your pharmacy to help with this. Important:

- **Forms without the needed information, that are not legible, or drug bill was not paid yet, may cause processing delay or denial**
- **Reimbursement is not guaranteed**

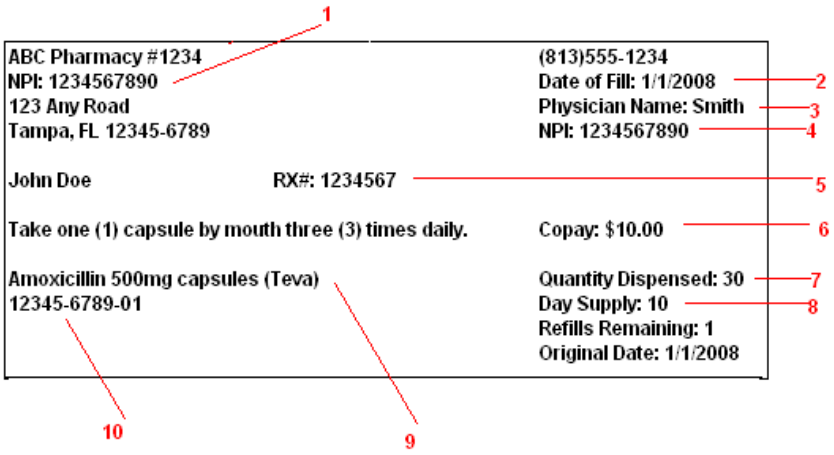
Please mail prescription label receipt(s), cash register receipts, and this completed form to:

WellCare Reimbursement Department
PO Box 31577
Tampa, FL 33631-3577

Please call us if you need help with this form. The Customer Service phone number is listed on the back of your member card.

Example Prescription Label

Below is a sample prescription label. Use this as a guide to find the information you need to complete this form. Each pharmacy has its own label format. Please ask your pharmacy to obtain any missing information.



1. **Pharmacy NPI (National Provider Identification)**
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 (National Drug Code for the drug filled)**

Who is making this request? Member ☐ Appointed Representative ☐

***Appointed Representatives*:**

- Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice

Complete the following section ONLY if the person making this request is not the member or prescriber:

Requestor's Name		
Requestor's Relationship to Member		
Address		
City	State	ZIP Code
Requestor Phone		

Representation documentation for requests made by someone other than member or the member's prescriber:

- **Attach documentation showing the authority to represent the member (a completed Authorization of Representation Form CMS-1696 or a written equivalent)**
- **For more information on appointing a representative, contact your plan or 1-800-Medicare**

Member Information

Member's Name:		
Member ID #:	Member Phone:	
Address:		
City:	State:	ZIP Code:

Reason for Request

☐	Drug received during hospital stay	☐	Copayment Discrepancy
☐	No Identification Card Available	☐	Pharmacy Unable to Process Claim Electronically
☐	Out of Network Pharmacy Used	☐	Vaccine
☐	Emergency – Please describe below	☐	Other – Please describe below

_____
_____
_____
_____
_____
_____

Clearly mark in this section the drug(s) you are asking for reimbursement. Only drugs listed in this section will be considered. Use more copies of this section of the form if you need more space. Dr. Name and NPI, please provide the physician information who prescribed the drug.

Requested Prescription Drug Information				
Drug Name	**Date of Fill**	**Quantity**	**Day Supply**	**Amount Paid**
NDC	**Physician Name/NPI**		**Pharmacy NPI**	**RX#**
Drug Name	**Date of Fill**	**Quantity**	**Day Supply**	**Amount Paid**
NDC	**Physician Name/NPI**		**Pharmacy NPI**	**RX#**
Drug Name	**Date of Fill**	**Quantity**	**Day Supply**	**Amount Paid**
NDC	**Physician Name/NPI**		**Pharmacy NPI**	**RX#**
Drug Name	**Date of Fill**	**Quantity**	**Day Supply**	**Amount Paid**
NDC	**Physician Name/NPI**		**Pharmacy NPI**	**RX#**
Drug Name	**Date of Fill**	**Quantity**	**Day Supply**	**Amount Paid**
NDC	**Physician Name/NPI**		**Pharmacy NPI**	**RX#**

I certify that the prescription(s) referred to above have been received and information stated is accurate. I certify that the patient for whom this claim is made is a covered person and that the prescription is for the sole use of the named patient. I release all information pertaining to the above claim(s) to the plan administrator, underwriter, sponsored policy holder and/or any person or entity acting on behalf of the patient at their request.

Enrollee Signature*: ___________________________________Date: __________

*If the individual cannot sign, a person who is authorized to do so under state law in the state where the individual resides must sign above. This signature certifies that the person signing is authorized under state law to complete this form and that all documentation of this authority is available upon request by the plan from the individual state Medicaid agency or by the Centers for Medicare & Medicaid Services, the federal agency that runs Medicare.

Discrimination is Against the Law

WellCare of Kentucky complies with all applicable federal civil rights laws. We do not exclude or treat people in a different way based on race, color, national origin, age, disability or sex.

We have free aids and services to help people with disabilities communicate with us. That includes help such as sign language interpreters. We can also give you info in other formats. Those formats include large print, audio, accessible electronic formats and Braille.

If English is not your first language, we can translate for you. We can also provide written info in other languages.

If you need these services, call us at **1-877-389-9457**. TTY users can call **711**. We're here for you Monday–Friday from 7 a.m. to 7 p.m.

Do you feel that we did not give you these services? Or do you feel we discriminated in some way? If so, you can file a grievance in person, by mail, fax, or email. You can reach us at WellCare of Kentucky Grievance Department, P.O. Box 31384, Tampa, FL 33631-3384. You can reach us by phone at **1-866-530-9491**; TTY **711**. Our fax is **1-866-388-1769**. Our email is **OperationalGrievance@wellcare.com**. If you need help filing a grievance, a WellCare of Kentucky Civil Rights Coordinator can help you.

You can also file a civil rights complaint online with the U.S. Dept. of Health and Human Services, Office for Civil Rights. Go to the Complaint Portal at **http://ocrportal.hhs.gov/ocr/portal/lobby.jsf**. File by mail to: U.S. Dept. of Health and Human Services, 200 Independence Ave. SW., Room 509F, HHH Building, Washington, DC 20201. You can call them at **1-800-368-1019**, **1-800-537-7697** (TTY).

You can get complaint forms at **http://www.hhs.gov/ocr/office/file/index.html**.

If English is not your first language, we can translate for you. We can also give you info in other formats. That includes Braille, audio and large print. Just give us a call toll-free. You can reach us at **1-877-389-9457**. For TTY, call **711**.

Si el español es su lengua materna, podemos brindarle servicios de traducción. También podemos proporcionarle información en otros formatos, como braille, audio y letra de imprenta grande. Simplemente, llámenos sin cargo al **1-877-389-9457**. Para TTY llame al **711**.

如果中文是您的母語，我們可以為您翻譯。我們也可以用其它格式為您提供資訊。這些格式包括布萊葉文、音頻及大字體。僅需撥打我們的免費電話。您可以撥打 **1-877-389-9457** 聯絡我們。TTY 用戶請撥打 **711**。

Wenn Deutsch Ihre erste Sprache ist, können wir für Sie übersetzen. Wir können Ihnen auch Informationen in anderen Formaten. Dazu gehören Braille, Audio und Großdruck. Rufen Sie uns einfach an. Sie erreichen uns unter **1-877-389-9457** (TTY **711**).

Nếu Tiếng Việt là ngôn ngữ chính của quý vị, chúng tôi có thể thông dịch cho quý vị. Chúng tôi cũng có thể cung cấp cho quý vị thông tin ở các định dạng khác như chữ nổi Braille, âm thanh và bản in cỡ lớn. Chỉ cần gọi chúng tôi theo số miễn phí **1-877-389-9457** (TTY **711**).

إذا كانت لغتك الاصلية هي اللغة العربية، فنحن بأستطاعنا الترجمة لك. ويمكننا أيضاً إعطائكم المعلومات في اشكال اخرى مثل طريقة البرايل للمكفوفين والصوت والمطبوعات ذات الحجم الكبير. هذه الخدمات تقدم مجاناً وبدون مقابل. فقط قم بالاتصال على رقم التلفون المجاني: **1-877-389-9457** أو (**711** TTY).

Ako srpsko-hrvatski je svoj prvi jezik, možemo prevesti za vas. Mi također mogu vam dati informacije u drugim formatima. To uključuje i Brailleovo pismo, audio i velike ispis. Samo nas nazovite besplatni. Možete nas kontaktirati na **1-877-389-9457** (TTY **711**).

日本語が母国語であれば、翻訳することができます。他の形式の情報も提供しています。それには、点字、音声、大型印刷物が含まれます。フリーダイヤルでご連絡ください。**1-877-389-9457** (TTY **711**) までお電話ください。

Si votre langue maternelle est le français, nous pouvons faire la traduction. Nous pouvons également vous fournir l'information dans des formats comme le braille, en version audio et imprimé en gros caractères. Il suffit de nous appeler au numéro sans frais **1-877-389-9457** (TTY **711**).

귀하의 모국어가 한국어 인 경우, 통역서비스를 제공해 드립니다. 점자, 오디오, 큰 활자 등 다른 형식으로 된 정보도 제공해 드릴 수 있습니다. 무료 전화 **1-877-389-9457** (TTY **711**) 번으로 전화 주십시오.

Als Pennsylvania Nederlands uw eerste taal, kunnen wij voor u vertalen. We geven u ook informatie in andere formaten. Dat geldt ook voor braille, audio en grote print. Geef ons een toll-free bellen. U kunt ons bereiken op **1-877-389-9457** (TTY **711**).

नेपाली आफ्नो पहिलो भाषा हो भने, हामी तपाईं को लागि अनुवाद गर्न सक्नुहुन्छ। हामी पनि तपाईं अन्य ढाँचामा जानकारी दिन सक्छ। त्यो ब्रेल, अडियो र ठूलो प्रिन्ट समावेश छ। बस हामीलाई एक कल निःशुल्क दिनु। तपाईं **1-877-389-9457** (TTY **711**) मा हामीलाई पुग्न सक्छ।

Oromoon Afaan kee kan jalqabaa yoo ta'e, siif hikuu ni dandeenya. Haala danaa biraatiinis odeffannoo siif kennu ni daneenya. Kunis karaa sirrina barreefama qaro-dhabeeyyii, sagalee fi maxxansa qubee gurgudaatiin ta'u danda'a. Kallatiin karaa bilbila kanfaltii maleetiin nuuf bilbilaa. Karaa **1-877-389-9457** (TTY **711**) tiin nu argu dandeessu.

Если русский Ваш основной родной язык, мы можем перевести для Вас. Мы также можем предоставить информацию в других форматах, например, на шрифте Брайля, записанную на аудионосителях и распечатанную крупным шрифтом. Просто позвоните нам по бесплатному номеру **1-877-389-9457** (TTY **711**).

Kung hindi ka nagsasalita ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika. Kasama dito ang Braille, audio at malalaking letra. Tumawag ng libre sa **1-877-389-9457** (TTY **711**).

Yaba Ikirundi ari rwo rurimi uvuga ubwa mbere, turashobora kugusigurira mu rundi rurimi. Turashobora kandi kukuronsa amakuru mu zindi foruma. Harimwo inyandiko ikoreshwa n'abatabona, amajwi twafashe ku vyuma n'inyandiko yanditse mu ndome niniya cane. Utegerezwa kuduhamagara gusa kuri telephone bahamagara ku buntu. Wodutera akamu kuri nomero **1-877-389-9457** (TTY **711**).