



Member Medical Reimbursement Claim Form

Use this claim form to be reimbursed for eligible out-of-pocket medical expenses. EMAIL form and required documents to: MemberReimbursements@Wellcare.com, OR FAX form and required documents to: 1-877-277-1805, OR MAIL form and required documents to: Fidelis Care Reimbursement Department • P.O. Box 31381 • Tampa, FL 33631-3381. Please submit one form per member.

IMPORTANT NOTE: Use this form when requesting reimbursement for **MEDICAL** services only. This form is **NOT** to be used for Pharmacy Reimbursements. Please contact your Benefit Administrator or Member Services if the request is for Pharmacy, Part D, routine Dental, Hearing, Transportation, Vision, Fitness or Flex card services. The contact information is on the back of your ID card.

For the reimbursement of Medical Services, FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. Completion of this form.

- Print your name and Member ID number as shown on your Fidelis Care ID Card.
- 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.
- 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 the following information:

- Date of each service.
- Place of each service – Doctor’s Office, Independent Laboratory, Outpatient Hospital, Inpatient Hospital, Nursing Home, Patient’s Home.
- 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 their 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.

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 false health care claims.

Printed Name: _____ Signature: _____

Date: _____

Fidelis Care network providers bill us directly for your covered services. This means you should not get a bill for covered services. If you do get a bill, send it to us. Do not pay the bill. We will work with your provider. However, if you already paid for covered services, Fidelis Care will review your request for reimbursement after you complete this form. Please 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 EMAIL form and required documents to: MemberReimbursements@Wellcare.com, OR FAX form and required documents to: 1-877-277-1805, OR MAIL form and required documents to: Fidelis Care Reimbursement Department • P.O. Box 31381 • Tampa, FL 33631-3381. If you have questions, please call Member Services at **1-888-453-2534** (TTY: **711**). We are here Monday through Friday, 8 a.m. to 6 p.m.

Fidelis Care 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.

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 **1-888-453-2534**. For TTY, call **711**.

Si el español es su idioma materno, podemos traducir la información para usted. También podemos proporcionarle información en otros formatos, entre ellos, Braille, audio y letra grande. Solo llámenos, sin costo alguno. Puede comunicarse con nosotros llamando al **1-888-453-2534**. Para TTY, llame al **711**.

若您中文是您的第一語言，我們可以為您翻譯。我們也提供其他格式的資訊，包括點字版、音訊和大字印刷。請致電免費專線 **1-888-453-2534**。TTY 請撥打 **711**。