missouricare
A WellCare Company

REFUND CHECK INFORMATION SHEET*(RCIS)

NOTE: Form must be completed in full, and used only when submitting 1 refund check per claim. <u>Not</u> 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 ____

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*ADDITIONAL INFORMATION REQUIRED FOR POSTING*____________________________________

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CONTACT NAME/PHONE/EMAIL ____

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