Children's Medical Services Health Plan
Operated by WellCare

Member Medical Reimbursement Claim Form

FAX form and required documents to **1-813-283-3284** OR
MAIL to WellCare Member Reimbursement Department • P.O. Box 31370 • Tampa, FL 33631
Use this claim form to be reimbursed for eligible out-of-pocket medical expenses.
Please submit one form per member.

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: _____ Parent/Guardian Signature: _____
Date:_____

HOW TO FILL OUT THIS FORM

FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. Completion of this form.

- Print your child's name like it is on the Children's Medical Services Health Plan ID Card
- Print your child's Member ID number
- State your child's mailing address and include the contact telephone number
- Tell us why you seek reimbursement
- Give us the date of service for which you seek reimbursement. (This is the date your child got the service.) List separately each date of service or admission date for inpatient/hospital stays
- Print the name of the doctor or facility that gave your child the service
- Tell us about the service that was provided. (Was this for travel? Add mileage.)
- State the amount you seek for the individual service line
- Add all individual lines together and state the total amount you seek

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 given
- Charge for each service
- Doctor's or supplier's name and address. At times, a bill will show the names of several doctors or suppliers. Please note: IT IS VERY IMPORTANT THAT YOU IDENTIFY THE ONE WHO TREATED YOUR CHILD. Just circle the name on the bill.

C. Proof of Payment documentation:

- Copy of canceled check (front and back)
- Credit card statement showing payment to provider
- Invoice/statement from provider showing the name, address, telephone number, date(s) of service, services provided 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. Please attach an itemized bill and payment receipt from your doctor or supplier. All requests will be processed within sixty (60) days of receipt. **Please note**: Your child's 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 PO Box 31370, Tampa, FL 33631 or fax to **813-283-3284**. If you have any questions please call Children's Medical Services Health Plan at **1-866-799-5321 (TTY: 711),** Monday – Friday from 8 a.m. to 7 p.m.

The Children's Medical Services Health Plan has partnered with WellCare of Florida, Inc. (WellCare) to provide managed care services to our members. WellCare is a licensed Florida health plan.