

## REFUND CHECK INFORMATION SHEET\*(RCIS)

**NOTE: Form must be completed in full, and used only when submitting 1 refund check per claim. Not 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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ADDITIONAL INFORMATION REQUIRED FOR POSTING \_\_\_\_\_

\_\_\_\_\_

CONTACT NAME/PHONE/EMAIL \_\_\_\_\_

\_\_\_\_\_

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