Member Reimbursement Claim Form

Member Name:_____ Member ID #: _____

Address:_____ Telephone: _____

City: _____ State: _____ ZIP Code: _____

Email: _____

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 claims.

Printed Name: _____ Signature:_____ Date:_____

HOW TO FILL OUT THIS FORM

FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. Completion of this form (must contain each of the following):

- Print your name as shown on your Wellcare ID Card.
- Print your Member ID number.
- Provide your mailing address and include your telephone number, and email address.
- 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.)
- Print the name of the doctor and/or facility that provided the service.
- **For a materials claim, please supply information on the provider who performed your exam and wrote your prescription.**
- 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. Proof of Payment documentation:

- Either a copy of canceled check (front and back)
- Or a credit card statement showing provider as paid
- Together with an 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

C. Delivery of this form:

- Email to **MemberReimbursement@embossspecialty.com**
- Fax to 1-855-865-9727
- Mail to Attn: Member Reimbursement, c/o Emboss Specialty, P.O. Box 21503, Eagan, MN 55121

Wellcare will review your request for reimbursement after you complete this form and 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.

Emboss Specialty, formerly Premier Eye Care, is an independent eye care provider contracted by Wellcare Medicare.