OVER-THE-COUNTER (OTC) ITEMS CLAIM FORM

FAX form and receipt to **1-877-849-5068** OR

MAIL form and receipt to WellCare/'Ohana OTC DMR Center • P.O. Box 31396 • Tampa, FL 33631-3396

Use this claim form to be reimbursed for eligible over-the-counter items. Please submit one form per member.

Member Name: _____ Member ID: _____

Address: _____ ❒ Check here if new address

City: _____ State: _____ ZIP Code: _____

Telephone: _____

Receipts must be submitted within 90 days of receipt date and are processed within 30 days of receipt. Do not send original receipts.

Purchase Date	Merchant Name	Merchant ZIP Code	Item Name/Description	Package Size	Total Item Cost
		(list URL if an online purchase)	*(if multiple count of same item, use a line for each count)*	*(i.e. 6 oz., 36 capsules/tablets)*	*(include any applicable tax in the total)*
					$
					$
					$
				Grand Total:	$

By signing this form, I confirm that the request for reimbursement is for eligible over-the-counter items and is not covered by any other plan or program. (If you have questions regarding eligible items, please refer to your OTC benefit information or call Customer Service at the number listed on the back of your member ID card.) OTC card members may only submit this OTC Items Claim Form in the event of card reader failure or system outage at the time of the point of sale.

Member's Signature: _____ Date: _____

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc. WellCare (HMO/HMO-POS/HMO SNP/HMO-POS SNP) is a Medicare Advantage organization with a Medicare contract and a contract with the state Medicaid program. Enrollment in WellCare/'Ohana (HMO/HMO-POS/HMO SNP/HMO-POS SNP) depends on contract renewal.

WellCare® Health Plans | 'Ohana℠ Health Plan

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Sample Receipt*:

#09396

Green Pharmacy
123 West Road
Tampa, FL 33634

08/13/13

Aspirin 325 mg.	$10.00
Daytime Cold Relief	$10.00
Candy	$6.00
SUBTOTAL	$26.00
TAX (7%)	$1.82
TOTAL	$27.82

Remember:

- ❒ Complete the claim form on the other side of this page.
- ❒ Include a copy of the receipt for the item(s) purchased.
- ❒ Your receipt must include the date of purchase and item(s) purchased. All fields must be completed for reimbursement. Handwritten receipts will not be accepted.
- ❒ For OTC card members only: OTC Items Claim Form is only allowed in the event of card reader failure or system outage at the time of point of sale.
- ❒ You may fax or mail your claim form and receipt, **but faxing provides faster customer service.**
- ❒ **FAX** your form and receipt to: WellCare/'Ohana OTC DMR Center at **1-877-849-5068**

OR

- ❒ **MAIL** your form and receipt to: WellCare/'Ohana OTC DMR Center • P.O. Box 31396 • Tampa, FL 33631-3396

To get more information or inquire how to get more claim forms, please contact Customer Service at one of the toll-free numbers listed in your OTC benefit information.

Sample Claim Form:

Purchase Date	Merchant Name	Merchant ZIP Code	Item Name/Description	Package Size	Total Item Cost
		(list URL if an online purchase)	*(if multiple count of same item, use a line for each count)*	*(i.e. 6 oz., 36 capsules/tablets)*	*(include any applicable tax in the total)*
8/13/2013	Green Pharmacy	33634	Aspirin 325mg	100 tablets	$10.70*
8/13/2013	Green Pharmacy	33634	Daytime Cold Relief	16 oz.	$10.70*
				Grand Total:	$21.40

*To calculate total item cost, multiply cost of item by 7% tax ($10.00 X .07 = $0.70) and add together ($10.00 + $.70 = $10.70).