TexanPlus®
A WellCare Company

Direct Member Reimbursement Form

Use this form when you pay full price for a covered prescription drug. Complete the form and send it to us to ask to be reimbursed. **Send the original prescription label receipt(s) with this form. Cash register and credit card receipts alone are not acceptable as proof of purchase. Forms without the required information can not be processed. Reimbursement is not guaranteed.**

Member Information

Name: ______________________ Date of Birth: ______________ ID Number: ____________

Street Address: ______________________ Apt/Unit #: ______________ Phone #: ____________

City: ______________________ State: ______________ Zip Code: ____________

Reason for Request

☐ No Identification Card Available
☐ Out of Network Pharmacy Used
☐ Emergency – Please Describe
☐ Copayment Inquiry
☐ Pharmacy Unable to Process Claim Electronically
☐ Other – Please describe

Pharmacy/Prescription Information

Please attach **detailed prescription label receipts.** Or you can ask your pharmacist to complete the remaining information. **See page 2 of this form for more space.**

We must have this information to process your claim.

Drug Name	Date of Fill	Quantity	Day Supply	Amount Paid
NDC	Dr. Name	Dr. NPI	Pharmacy NPI	RX#

Special Instructions:

We must be able to clearly read the information on the prescription label receipt, or your claim may be delayed or denied. Please mail prescription label receipt(s), cash register receipts and this completed form to:

TexanPlus
Reimbursement Department
PO Box 31577
Tampa, FL 33631-3577

I certify that the prescription(s) referred to above have been received and information stated is accurate. I certify that the patient for whom this claim is made is a covered person and that the prescription is for the sole use of the named patient. I release all information pertaining to the above claim(s) to the plan administrator, underwriter, sponsored policy holder and/or any person or entity acting on behalf of the patient at their request.

Enrollee Signature*: ______________________________ Date: ________________

*If the individual cannot sign, a person who is authorized to do so under state law in the state where the individual resides must sign above. This signature certifies that the person signing is authorized under state law to complete this form and that all documentation of this authority is available upon request by the plan from the individual state Medicaid agency or by the Centers for Medicare & Medicaid Services, the federal agency that runs Medicare.

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Example Prescription Label

Below is a sample prescription label. Use this as a guide to find the information you need to complete this form. Each pharmacy has its own label format. Please contact your pharmacy to obtain any missing information.

ABC Pharmacy #1234
NPI: 1234567890 (1)
123 Any Road
Tampa, FL 12345-6789

(813)555-1234
Date of Fill: 1/1/2008 (2)
Physician Name: Smith (3)
NPI: 1234567890 (4)

John Doe
RX#: 1234567 (5)

Take one (1) capsule by mouth three (3) times daily.
Copay: $10.00 (6)

Amoxicillin 500mg capsules (Teva) (9)
12345-6789-01 (10)

Quantity Dispensed: 30 (7)
Day Supply: 10 (8)
Refills Remaining: 1
Original Date: 1/1/2008

1. Pharmacy NPI
2. Date of Filld
3. Physician Name
4. Physician NPI Number
5. Prescription (RX) Number
6. Amount Paid
7. Quantity Dispensed
8. Day Supply
9. Drug Name
10. NDC

Pharmacy/Prescription Information (Continued from Page 1)

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NDC	Dr. Name	Dr. NPI	Pharmacy NPI	RX#
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If you need help with this form, please call us. Call the Customer Service phone number listed on the back of your membership card.

TexanPlus® HMO and TexanPlus® HMO-POS are Medicare Advantage plans with a Medicare contract. TexanPlus® HMO-SNP is a Medicare Advantage plan with a Medicare contract and a contract with the State Medicaid Program. Enrollment in these plans depend on contract renewal. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

TexanPlus® HMO, TexanPlus® HMO-POS, and TexanPlus® HMO-SNP comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-736-7442 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-736-7442 (TTY: 711). Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-736-7442 (TTY: 711)。