Dear Wellcare Member,

Enclosed is the Direct Member Reimbursement Form, as requested.

For proper processing, please fill out the form completely using the below checklist:

☐ Print your name as shown on your Health Plan ID Card.
☐ Print your Member ID Number as shown on your Health Plan ID Card.
☐ Print your mailing address, telephone number and email address.
☐ A description of why you are requesting reimbursement in the section provided.
☐ The date(s) of service for each service you are requesting reimbursement for.
☐ We will need the following service provider information to process your claim:
- **The first and last name, address and NPI 1 number of the doctor who completed your exam and wrote your prescription. (aka "Referring Provider")**
- **The name, address and NPI 2 number(s) of the location(s) where you got service(s)**

☐ 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 for all services
☐ Please sign and date form
☐ A **copy** of the front and back of a canceled check **OR** a **copy** of bank or credit card statement showing payment
☐ A **copy** of an invoice/statement from the provider showing the following:
- Provider's Name, Address & Telephone
- Date of Service
- Services Rendered
- Balance showing paid with payment method – cash, check or credit card

Your bill must be paid in full before your reimbursement can be processed. Only services paid by personal funds at an Out-of-Network provider are eligible for reimbursement. Payments made using a Wellcare Flex Card or Spendables Card are not eligible for reimbursement.

Delivery of this form:

Email: MemberReimbursement@premiereyecare.net
Fax: 1-855-865-9727
Mail: Attn: Member Reimbursement, c/o Premier Eye Care,
P.O. Box 21503, Eagan, MN 55121

Once all requested information has been received and meets your plan's reimbursement requirements, your request will be processed within 60 days.

Please feel free to contact Premier Eye Care at the above email if you have any additional questions.

Thank you,

MEMBER REIMBURSEMENT
PREMIER EYE CARE

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:_____