

# HealthStuff™ (Over-the-Counter) Items Reimbursement Form

Fax form and receipt to 1-813-849-6336.

Use this claim form for *over-the-counter items* covered by 'Ohana reimbursements only.

Member Name: \_\_\_\_\_ Member ID: \_\_\_\_\_

Check here if new address

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

( )

Telephone: \_\_\_\_\_ E-mail Address\* (optional): \_\_\_\_\_

*\*By providing your e-mail address, you agree to accept future 'Ohana correspondence by e-mail.*

Receipts must be submitted within 90 days of receipt date and are processed within 30 days of receipt by 'Ohana.

Date Purchased

Item(s) Purchased

Amount

1. \_\_\_\_\_ \$ \_\_\_\_\_

2. \_\_\_\_\_ \$ \_\_\_\_\_

3. \_\_\_\_\_ \$ \_\_\_\_\_

4. \_\_\_\_\_ \$ \_\_\_\_\_

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 HealthStuff™ catalog.)

Member's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.

**Remember:**

Complete the claim form (page 1).

Also include receipt for item(s) purchased.

Your receipt must include the date of purchase and item(s) purchased.

You may fax or mail your claim form and receipt, **but faxing provides faster customer service.**

**Fax your form and receipt to:** Acclaris Reimbursement Center at 1-813-849-6336

**OR**

**Mail your form and receipt to:** Acclaris Reimbursement Center • P.O. Box 25117 • Lehigh Valley, PA 18002

To get more information or to request additional claim forms, please contact Customer Service at 1-888-505-1201

TTY/TDD: 1-877-247-6272 • Monday–Sunday, 8am to 8pm HST. Or visit us at [www.ohanahealthplan.com](http://www.ohanahealthplan.com).

**SAMPLE  
RECEIPT**

#09396

08/13/08

Tylenol	\$10.00
Cough Syrup	\$10.00
Candy	\$6.00

<b>SUBTOTAL</b>	<b>\$26.00</b>
<b>TAX</b>	<b>\$0.42</b>
<b>TOTAL</b>	<b>\$26.42</b>

**SAMPLE  
REIMBURSEMENT  
INVOICE**

<b>Date Purchased</b>	<b>Item(s) Purchased</b>	<b>Total</b>
August 13, 2008	Tylenol	\$10.00
August 13, 2008	Cough Syrup	\$10.00

<b>Grand Total</b>	<b>\$20.00</b>
<b>Member Reimbursement Amount</b>	<b>\$20.00</b>