Member Medical Reimbursement Claim Form

'ohana health plan™

Use this claim form to be reimbursed for eligible out-of-pocket medical expenses.

EMAIL form and required documents to: **MemberReimbursements@Wellcare.com**, OR
FAX form and any required documents to **1-813-283-3284** OR
MAIL form and required documents to 'Ohana Member Reimbursement Department • P.O. Box 31381 • Tampa, FL 33631-3381.

Please submit one form per member.

IMPORTANT NOTE: Use this form when requesting reimbursement (repayment) for **MEDICAL** services only. This form is **NOT** to be used for pharmacy reimbursements. Please contact Customer Service if the request is for pharmacy, dental, hearing, transportation (ride), or vision services. Call toll-free at **1-888-846-4262** (TTY: **711**) Monday through Friday, from 7:45 a.m. to 4:30 p.m., Hawaii Standard Time.

For the reimbursement of medical services, ***FOLLOW THESE INSTRUCTIONS CAREFULLY:***

A Completion of the member medical reimbursement claim form:

- Print your name and member ID number as shown on your 'Ohana ID Card.
- Provide your mailing address and telephone number.
- Describe why you are asking for reimbursement.
- Provide the date of service for which you are requesting reimbursement. This is the date the service was given. List separately each date of service or admission date for inpatient / hospital stays.
- Print the name of the doctor, provider, or facility that provided the service.
- 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 Each itemized bill MUST include all the following information:

- Date of each service.
- Place of each service, such as a doctor's office, independent laboratory, outpatient hospital, inpatient hospital, nursing home, or the patient's home.
- Description of each surgical or medical service or supply furnished.
- Charge for EACH service.
- Doctor or provider's name and address. A bill will often show the names of several doctors or providers. **IT IS VERY IMPORTANT THAT YOU IDENTIFY THE ONE WHO TREATED YOU.** Simply circle their name on the bill.

C Proof of payment documentation:

- Copy of canceled check (front and back).
- Credit card statement showing provider as paid.
- Invoice / statement from provider showing provider's name, address, and telephone number.

Member Name _____ Member ID #_____

Address _____ Telephone _____

City _____ State _____ ZIP Code _____

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 healthcare claims.

Printed Name: _____ Signature: _____ Date: _____

ʻOhana Health Plan will review your request for reimbursement after you complete this form. Please attach an itemized bill and payment receipt from your doctor or provider. 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. All required documentation must be included with the request. **EMAIL** form and required documents to: **MemberReimbursements@Wellcare.com**, OR **FAX** form and any required documents to **1-813-283-3284** OR **MAIL** form and required documents to ʻOhana Member Reimbursement Department • P.O. Box 31381 • Tampa, FL 33631-3381. Please submit one form per member.

OhanaHealthPlan.com

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‘Ohana Health Plan complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat people differently because of race, color, national origin, age, disability or sex.

‘Ohana Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

‘Ohana Health Plan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact ‘Ohana Health Plan toll-free **1-888-846-4262** (TTY **711**).

If you believe that ‘Ohana Health Plan has failed to provide these services or discriminated in another way, you can file a grievance with:

1557 Coordinator
P.O. Box 31384
Tampa, FL 33631
Phone: **1-888-318-0427** (TTY: **711**)
Fax: **1-866-388-1769**
Email: **SM_Section1557Coord@centene.com**

You can file a grievance by mail, fax, or email. If you need help filing a grievance, our **1557 Coordinator** is available to help you.

You can also file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, **1-800-537-7697** (TDD)

Complaint forms are available at **https://www.hhs.gov/ocr/complaints/index.html**.

(English) Do you need help in another language? We will get you a free interpreter. Call **1-888-846-4262** (TTY: **711**).

(Cantonese) 您需要其他語言的協助嗎？我們提供您免費的口譯服務。請致電 **1-888-846-4262** (TTY：**711**)。

(Chuukese) En mi mochen emon chon awewe/chon chiaku non pwan ew fos? Sipwe angei emon chon chiaku esapw kame. Kekkeri **1-888-846-4262** (TTY: **711**).

(French) Vous avez besoin d'aide dans une autre langue ? Nous vous trouverons un interprète gratuitement. Appelez le **1-888-846-4262** (TTY : **711**).

(German) Benötigen Sie Hilfe in einer anderen Sprache? Wir stellen Ihnen kostenlos einen Dolmetscher zur Verfügung. Sie erreichen uns unter: **1-888-846-4262** (TTY: **711**).

(Hawaiian) Pono ʻoe i ke kōkua ma ka ʻōlelo ʻē aʻe? E loaʻa iā mākou kahi unuhi ʻōlelo unuhi ʻōlelo. E kelepona iā **1-888-846-4262** (TTY: **711**).

(Ilocano) Masapulmo kadi ti tulong iti sabali a lengguahe? Ipaayandaka iti libre nga interpreter. Umawag iti **1-888-846-4262** (TTY: **711**).

(Japanese) 他の言語でのサポートが必要ですか?通訳を無料でご用意します。**1-888-846-4262** (TTY: **711**)までお電話ください。.

(Korean) 다른 언어로 도움을 받으셔야 합니까? 무료 통역사를 지원해 드립니다. **1-888-846-4262** (TTY: **711**)번으로 연락해 주십시오.

(Mandarin) 您是否需要其他语言的帮助？我们将为您提供免费的翻译服务。请致电 **1-888-846-4262** (TTY: **711**)。

(Marshallese) Kwōj ke aikuj jibañ kin bar juon kajin? Kim naj lewaj juon riukok ejellok wonnen. Kūrlok **1-888-846-4262** (TTY: **711**).

(Samoan) O e manaomia se fesoasoani i se isi gagana? Matou te sueina se faaliliu upu e le totogiina. Vala'au le **1-888-846-4262** (TTY: **711**).

(Spanish) ¿Necesita ayuda en otro idioma? Le conseguiremos un intérprete gratuito. Llame al **1-888-846-4262** (TTY: **711**).

(Tagalog) Kailangan ba ninyo ng tulong sa ibang wika? Ikukuha namin kayo ng libreng tagasalin. Tumawag sa **1-888-846-4262** (TTY: **711**).

(Tongan) ʻOku ke fiemaʻu tokoni ʻi ha toe lea kehe? Te mau ʻomi taʻetotongi ha tokotaha fakatonulea. Tā ki he **1-888-846-4262** (TTY: **711**).

(Vietnamese) Quý vị có cần trợ giúp bằng ngôn ngữ khác không? Chúng tôi sẽ cung cấp cho quý vị một phiên dịch viên miễn phí. Hãy gọi đến số **1-888-846-4262** (TTY: **711**).

(Visayan) Nagkinahanglan ka bag tabang gikan sa laing pinulongan? Hatagan ka namo og libreng tighubad. Tawag sa **1-888-846-4262** (TTY: **711**).