

This form allows WellSense Medicare Advantage plan members to request reimbursement for the quarterly over-the-counter (OTC) card allowance. Medicare Advantage plan members with an OTC or OTC + Vision Debit Card can use this form to request reimbursement for eligible OTC and health-related items that you purchased at any participating retailers.

- WellSense Added Value (HMO) - \$275 per quarter
- WellSense Choice (HMO) - \$125 per quarter
- WellSense Signature (HMO) - \$100 per quarter
- WellSense Signature Access (PPO) - \$75 per quarter

Reimbursement will only be approved for authorized OTC items. Approved reimbursement amounts will be deducted from the balance of your OTC or OTC + Vision Debit Card for the calendar quarter (January, April, July, October) in which covered items were purchased. In the event the balance is less than the amount submitted, you will be reimbursed only up to the amount of your card balance at the time your request is received.

To submit a request for reimbursement, please follow the instructions below and complete this form and all its pages. You must be a member of WellSense Medicare Advantage at the time of purchase, and your receipt must be for qualified items purchased before December 31. Reimbursements should be submitted within one year of the date of purchase. Please contact Member Service at 855-833-8125 (TTY: 711) 8 a.m. to 8 p.m., Monday through Friday (we are open seven days a week from Oct. 1 through March 31) if you have any questions.

## Member Information (Please print information clearly)

Member ID number (found on your member ID card)

Last name

First name, Middle initial

Address

City

State

Zip code

Phone

**Purchase Information (Required)**

A receipt is required for purchased items, with the retailer's name and address preprinted on the receipt, with items listed and the amount paid.

Store name and location:

Description of items purchased:

Reimbursement amount requested:

**Certification and authorization** (This form must be signed below).

I certify that the information provided in support of this submission is complete and correct, that I have only purchased qualified expenses, and that I have not previously submitted for this reimbursement.

Member's Signature

Date

To submit your request for determination, please send to:

WellSense Medicare Advantage

Member Service

100 City Square, Suite 200

Charlestown, MA 02129

Fax: 617-897-0884

Email: [MemberQuestions@wellsense.org](mailto:MemberQuestions@wellsense.org)