NHMA OTC + Vision Debit Card Reimbursement Form

This form allows WellSense Medicare Advantage members enrolled in WellSense Added Value (HMO) and WellSense Choice (HMO) plans to request reimbursement for their annual vision service allowance. WellSense Medicare Advantage plan members with an OTC + Vision debit card can use this form to request reimbursement for vision services and hardware from an authorized vision provider.

- WellSense Added Value (HMO)- $400 per year
- WellSense Choice (HMO) - $200 per year

Reimbursement will only be approved for authorized vision services and hardware. Approved reimbursement amounts will be deducted from the yearly balance of their OTC + Vision debit card for the calendar year 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			

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WellSense HEALTH PLAN

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