Wellmark Advantage Health Plan

Member Reimbursement Form

This form is used when payment was made directly to your provider.
Please fill out, sign, and mail this form with original receipts to:

WMAHP Member Correspondence
P.O. Box 261125
Plano, TX 75026

Member ID: (*found on your Wellmark Advantage Health Plan ID card)*				
First Name:		Last Name:		
Street Address:				
City:			State:	ZIP code:
Date of Birth:	Phone Number:	Date of Service:	Was this Related to an Auto Accident? Yes☐ No☐	
Was this Work Related? Yes☐ No☐		Other Health Insurance? Yes☐ No☐		
Name of other Health Insurance:		Policy Number:		

In order to process your request, please:

- Complete one form for each service
- Mail original itemized bill that includes the following:
  - Provider name and NPI
  - Date of service
  - Charge
  - Procedure description and/or code*
  - Diagnosis description and/or code*

  **Doesn't apply for flu shots*
- Please keep a copy of your original bill for your files

I certify the above information is true, and the enclosed material is correct and unaltered.

Signature:	Date: