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Wellmark BlueCross BlueShield of Iowa
An Independent Licensee of the Blue Cross and Blue Shield Association

PO Box 9291
Des Moines, Iowa 50306-9291

MEMBER CLAIM FORM

A SEPARATE CLAIM FORM MUST BE SUBMITTED FOR EACH PATIENT WHEN SENDING BILLS TO WELLMARK BLUE CROSS AND BLUE SHIELD OF IOWA

PLEASE REFER TO THE INSTRUCTION ON THE BACK OF THIS FORM WHEN FILING YOUR CLAIMS.

Identification Number (as indicated on your identification card including the three-digit prefix)	Group Number

Patient's information

Patient's Last Name	Complete First Name	MI	Date of Birth
			/ /

Gender	Patient's Relationship to Policy/Certificate Holder
☐ Male ☐ Female	☐ Self ☐ Spouse ☐ Child ☐ Other (Specify)

Description of illness or injury requiring treatment	Date Illness Began
	/ /

Was this an accident?	If yes, date of accident	Was this an automobile accident?	Was the illness/accident related to employment
☐ Yes ☐ No	/ /	☐ Yes ☐ No	☐ Yes ☐ No

Was patient a full time Student?	If yes, what school?
☐ Yes ☐ No	

Other Insurance - This part must be completed in full before we can determine responsibilities for your claim

Do you have Medicare? Part A: ☐ No ☐ Yes; Effective Date ____/____/____ Part B: ☐ No ☐ Yes; Effective Date ____/____/____
If yes, please file the claim with Medicare first. Then submit a copy of your Explanation of Medicare Benefits with this form.

Is the patient covered by other medical insurance? ☐ Yes ☐ No
If yes, and the policy is with a group (such as through an employer or Farm Bureau), please complete the following section.

Name of insured policyholder	Name and address of insured's employer

Name and address of other insurance company	Policy Number (other insurance co.)

Type of coverage	Has the other insurance company paid?	If yes, please submit a copy of their payment information with this form.
☐ Single ☐ Family	☐ Yes ☐ No	

Policy/Certificate Holders Information

Policy/Certificates Holder's Last Name	Complete First Name	MI	Policy/Certificate Holder's Employer

Policy/Certificates Holder's Address	City	State	Zip Code	Date of Birth
				/ /

I certify the above is complete and correct and that I am claiming benefits for charges incurred by the patient named above. I authorize any health care provider to release medical records to Wellmark Blue Cross and Blue Shield of Iowa when resonably related to the health care claims submitted. If any law or regulation requires additional authorization for release of medical records, I will give this authorization.

Policy/Certificate Holder's Signature_____ Date_____/_____/_____

Other Services and Supplies not Filed by Provider or Hospital (Attach a legible copy of original itemized receipts)

These may include office visits, hospital visits, physical therapy, diabetic supplies, ambulance services, medical appliances, etc.

If services were rendered outside the USA, please indicate:	Country	Currency Used

Date of Service (MM/DD/YY)	Description of Service / Supplies	Diagnosis or Symptoms you Sought Treatment For	Charge

Provider Information

Name	Tax ID	NPI

Address	City	State	Zip Code	Place of Service

MEMBER CLAIM FILING INFORMATION (HOW TO FILE)

Be sure to ask your provider of care if he/she bills Wellmark Blue Cross and Blue Shield of Iowa. Please submit itemized bills **only if** the provider does not bill us directly. To receive benefits for drugs, or for services by a provider who does not bill us directly, **complete** the claim form, **attach** itemized bills, and **mail to: Wellmark Blue Cross and Blue Shield of Iowa, PO Box 9291, Des Moines, Iowa 50306-9291.** Please do not use highlighter pens.

INSTRUCTIONS

A separate claim form must be submitted for each family member and each health care provider for all benefits except prescription drugs. More than one pharmacy per family member may be listed when submitting a claim for prescription drugs.

1. Please complete all blanks.
2. Accurate answers to these questions will allow us to coordinate benefits with other sources of payment. This is also to insure prompt and proper handling of your claim.
3. Your signature attests to the accuracy and completeness of all information on the claim and the attachments and authorizes the release of your medical records by the provider to our office if necessary. Your telephone number will assist us if additional information is required.
4. Write in the date services were provided.
5. Write in reason for medical care or diagnosis.

REQUIRED INFORMATION FOR ITEMIZED BILLS

Itemized Bills: Summarizing the services may help us better understand the attachments if they are not clear. The **attached** itemized bills must include the provider name and address, patient name, date of service, detailed description of service, place of service, amount charged for that service, and diagnosis. These must be valid documents from the provider. Cancelled checks, cash register receipts, or personally prepared bills will not be accepted. Please do not use highlighter pens.

Pharmacy Claim: Prescription drug bills should include date of purchase, prescription number, drug name, NDC number, strength and quantity, pharmacy name and charge for each prescription.

Psychotherapy: Length and type of session (group or individual). Name and professional status of the individual conducting the session.

Home Skilled Nursing Services: Name, and professional status (RN or LPN) of the nurse. Dates of service and a letter from the attending physician certifying that such service was medically necessary.

Medicare: If the patient is eligible for Medicare benefits, you must attach a copy of the explanation of Medicare benefits corresponding with each of the charges on the itemized bill submitted with this claim form. This claim cannot be processed without this information.

Other Insurance: If the patient has received benefits under another insurance program, please attach a copy of the payment document.

HELPFUL HINTS

- If you have questions or need assistance, contact Wellmark Blue Cross and Blue Shield of Iowa.
- To reduce the possibility of small billings getting lost or separated, it would be helpful if you attach these to an 8½**x**11 piece of paper. Please do not use highlighter pens.
- File as soon as possible after the date of service. Your claim must be filed within 365 days from the service date.
- File only if the provider has not.
- No part of your claim can be returned. If you need any of the itemized bill for your records, make a copy before mailing the claim.

Important: If the services for this claim were provided by a participating or contracting physician or hospital, the benefit payment will be made to the provider.

Mail to: **Wellmark Blue Cross and Blue Shield of Iowa**
Station 39
PO Box 9291
Des Moines, Iowa 50306-9291