Wellmark Blue Cross and Blue Shield of Iowa is an Independent Licensee of the Blue Cross and Blue Shield Association.

Mail Station 1E238
PO Box 9291
Des Moines, Iowa 50306-9291

MEMBER CLAIM FORM

Save | Clear 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, Mail Station 1E238, 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.
6. Place of service must be filled in with one of the following: Inpatient, Outpatient, Office, Home, Independent Lab, Extended Care Facility/Skilled Nursing Facility, Ambulance, Other.

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 by the timely filing deadline. Please refer to your coverage document for the specific timely filing guideline.
- 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**
Mail Station 1E238
PO Box 9291
Des Moines, Iowa 50306-9291

Required Federal Accessibility and Nondiscrimination Notice

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- 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, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint 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, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي : 888-781-4262).

ສ່ຽງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တ၀်ဒုးသ့ဉ်ညါ–နမ့်ကတိၤကညီကျိာ်.ကျိာ်တ်မၤစၤတ်ဖံးတ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.အိဉ်လၢနဂီၢ်လီၤ. ဆဲးကျိးဆူ၀၀–၅၂၄–၉၂၄၂မ့တမ့်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ာ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ አገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 መደም (በTTY: 888-781-4262) ይውለው ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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