Member Submitted Claim Form

Thank you for being a member of Wellmark Blue Cross and Blue Shield. Please review the instructions below for helpful information on how to submit your claim so it processes quickly and accurately. **Note:** *All fields on this form are required in order to be processed correctly. Incomplete claim forms will not be processed. Complete the form using a blue or black pen. Please do not use highlighters.*

This claim form is for health care services received inside the United States. If services were provided outside the U.S., please use the Blue Cross and Blue Shield Global™ Claim Form. For prescription drugs, please use the Prescription Reimbursement Claim Form.

Member Instructions - Section 1

1. Complete section 1 and sign the form. Ask your physician or health care provider to complete section 2.
2. Submit a separate claim form for each family member and each provider of health care service. Retain copies of all documents for your records.
3. Submit completed form (section 1 and 2) and any receipts and itemized statements to: Wellmark Blue Cross and Blue Shield - Mail Station 1E238 - PO Box 9291 - Des Moines, IA 50306-9291

Please file your claim as soon as possible after receiving care. For specific filing deadlines refer to the Claims section of your Wellmark Coverage Manual for more details. If you have questions or need assistance go to Wellmark.com or call Customer Service at the phone number shown on the back of your Wellmark ID card.

Physician/Provider Instructions - Section 2

1. Complete section 2 and sign form.
2. Return completed form to the policy holder/patient or mail it to the address listed above on the patient's behalf.

Section 1 - Member

ID Card Information

Policyholder's Identification Number on ID Card:
(include any letters)

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Policyholder's Name on ID Card: (first name, middle initial, last name)

Policyholder's Date of Birth: _____/_____/_____

Policyholder's Address:

_____

_____

Patient Information (if different from Policyholder)

Patient First Name: | Patient Last Name:

Patient's Date of Birth: _____/_____/_____

Patient's Relationship to Policyholder:
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient's Address: (if different from Policyholder)

_____

_____

I certify that the information given is complete and correct, and that I am claiming benefits only for charges incurred by the patient named above.
Policy/Certificate Holder's Signature:_____ Date:_____/_____/_____

Section 2 - Provider

Services and Provider of Service Information - To be filled out by the Provider

For services related to hospitalization or long-term care facility please provide the following:
Admission Date: _____/_____/_____ Discharge Date: _____/_____/_____

From Date of Service MM/DD/YYYY	To Date of Service MM/DD/YYYY	HCPCS/CPT/ADA Code including Modifier	Description of Service/Supply	Diagnosis Code	Charges	Days or Units
					$	
					$	
					$	
					$	
					$	
				Total amount billed/charged:	$	
				Amount paid by member:	$	

Provider of Service Name:	Tax ID:	Billing NPI:
Address (location where services were provided):	City, State and ZIP:	Place of Service: ☐ Inpatient ☐ Outpatient ☐ Office ☐ Other_____
Referring/Rendering Provider Name:	Referring/Rendering Provider NPI:	

I certify these services were performed by me or in my presence under my supervision.

Provider of Service Signature:_____ Date: _____/_____/_____

C-2318978 5/17 AN-T

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: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ 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, नि:शुल्क 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).

တၢ်နုးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂီၢ်လီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

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 नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይሙሉ 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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