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

PLEASE FOLLOW THE INSTRUCTIONS ON THE BACK OF THIS CLAIM FORM IN ORDER TO COMPLETE THE FOLLOWING. (ONE PATIENT PER CLAIM FORM.)

PATIENT AND POLICYHOLDER INFORMATION

PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH MO. | DAY | YEAR	POLICYHOLDER'S NAME (LAST, FIRST, MIDDLE INITIAL)
PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP)	PATIENT'S SEX ☐ MALE ☐ FEMALE PATIENT'S RELATIONSHIP TO INSURED ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER	POLICYHOLDER'S PREFIX AND IDENTIFICATION NO. OTHER NUMBERS OR LETTERS AS THEY APPEAR ON YOUR IDENTIFICATION CARD
IS PATIENT COVERED BY ANY OTHER GROUP HEALTH POLICY, PLAN OR PROGRAM? ☐ NO ☐ YES, COMPLETE THE FOLLOWING OTHER INSURANCE COMPANY NAME: _____ OTHER INSURANCE COMPANY ADDRESS: _____ STREET CITY STATE ZIP NAME OF POLICYHOLDER: LAST FIRST INITIAL POLICY NUMBER: POLICY EFFECTIVE DATE: OTHER POLICYHOLDER'S DATE OF BIRTH:	WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT? ☐ YES ☐ NO B. AN ACCIDENT? ☐ YES ☐ NO DATE OF ACCIDENT: IF PATIENT IS OVER 18 YEARS, INDICATE IF: ☐ STUDENT (INCLUDE SCHOOL NAME, ADDRESS) ☐ DISABLED ☐ MEDICARE COVERED	POLICYHOLDER'S HOME ADDRESS (STREET, CITY, STATE, ZIP) ☐ CHECK HERE IF NEW ADDRESS POLICYHOLDER'S HOME PHONE NUMBER ( ) POLICYHOLDER'S WORK PHONE NUMBER ( )

CLAIM INFORMATION (USE SEPARATE CLAIM FORM FOR EACH DOCTOR OR HOSPITAL)
FOR PHARMACY CLAIMS, SEE REVERSE SIDE FOR SPECIFIC INSTRUCTIONS.

DATE OF SERVICE	REASON FOR MEDICAL CARE/DIAGNOSIS
PROVIDER NAME (DOCTOR, HOSPITAL, PHARMACY, OR OTHER)	
PROVIDER ADDRESS (STREET, CITY, STATE, ZIP)	

PLEASE ENCLOSE ITEMIZED BILLS FOR SERVICES LISTED ABOVE. DO NOT STAPLE

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. I authorize any health care provider to release medical records to Wellmark Blue Cross and Blue Shield of Iowa when reasonably 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.

SIGNED X DATE

C-5321 2/05

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.

Private Duty Nursing: 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. For services in: 2004 your claim must be filed by: Dec. 31, 2005
  2005 Dec. 31, 2006
  2006 Dec. 31, 2007
- 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