



1601 W. Madison
Sioux Falls, South Dakota 57104

MEMBER CLAIM FORM

An Independent Licensee of the Blue Cross and Blue Shield Association

A SEPARATE CLAIM FORM MUST BE SUBMITTED FOR EACH PATIENT WHEN SENDING BILLS TO WELLMARK BLUE CROSS AND BLUE SHIELD OF SOUTH DAKOTA
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
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Patient's information

Patient's Last Name	Complete First Name	MI	Date of Birth / /
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Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's Relationship to Policy/Certificate Holder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify)
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Description of illness or injury requiring treatment	Date Illness Began / /
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Was this an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date of accident / /	Was this an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was the illness/accident related to employment <input type="checkbox"/> Yes <input type="checkbox"/> No
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Was patient a full time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what school?
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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
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Name and address of other insurance company	Policy Number (other insurance co.)
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Type of coverage <input type="checkbox"/> Single <input type="checkbox"/> Family	Has the other insurance company paid? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please submit a copy of their payment information with this form.
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Policy/Certificate Holders Information

Policy/Certificates Holder's Last Name	Complete First Name	MI	Policy/Certificate Holder's Employer
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Policy/Certificates Holder's Address	City	State	Zip Code	Date of Birth / /
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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 South Dakota 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.

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

Provider Information

Name	Tax ID	NPI
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Address	City	State	Zip Code	Place of Service
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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 South Dakota. 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 South Dakota, 1601 W. Madison Sioux Falls, South Dakota 57104**. 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 South Dakota.
- To reduce the possibility of small billings getting lost or separated, it would be helpful if you attach these to an 8½x11 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 South Dakota
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