



An Independent Licensee of the Blue Cross and Blue Shield Association

APPEAL/REVIEW FORM

PLEASE PRINT OR TYPE ALL INFORMATION

This form is to be completed by you, as a covered member, or your authorized representative, if you have designated one, if you disagree with a benefit determination or request a review of a claim for benefits.

Member Information

Member Name: _____ Identification Number (from your ID card): _____

If your appeal is related to an application submitted to Wellmark, please include the tracking and/or offer number from the letter you received from Wellmark: _____

Patient Name: _____ Telephone Number: _____

Mailing Address: _____

Requester's Information

If you are requesting an appeal on behalf of the member, a Personal Representative Appointment and Authorized to Release Protected Health Information Form must be completed and either be submitted with this form or on file with Wellmark. A member may appoint only one authorized representative at a time.

This appeal is being requested by (Full Name): _____

Mailing Address: _____

Telephone Number: _____

Relationship to Member: _____

Claim Information (found on the front of the Explanation of Health Care Benefits or letter of denial or reduction)

Has the service in question already been provided?

Yes No

Date of Service(s): ____/____/____; ____/____/____ Date of Denial: ____/____/____

Provider Name: _____ Provider Name: _____

Claim Number(s): _____ Date of declination/offer letter: _____

Please provide an explanation of your appeal and attach any and all additional documentation that may assist us in our review. Include what action you would like to see taken and use separate sheets if additional space is necessary. **Your request for a grievance must be filed within 180 days of the date on the Explanation of Health Care Benefits or letter of denial or reduction.** You will receive a written response to your request within the time required by law.

Are there documents attached? (Please retain a copy for yourself) Yes No

Signature: _____ Date: ____/____/____

Mail to:
Wellmark Blue Cross and Blue Shield
Member Appeals, Station 351
PO Box 5023
Sioux Falls, SD 57117-5023
