



PO Box 5023
Sioux Falls, South Dakota 57117-5023

Routine Vision Claim Form

An Independent Licensee of the Blue Cross and Blue Shield Association

Member ID (include prefix and identification number)

Patient Last Name	First Name
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Patients Street Address

City	State	Zip Code
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Home Phone ()	Patients Gender <input type="checkbox"/> M <input type="checkbox"/> F	Patients Date of Birth / /	Patients Relationship to Member <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
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Subscribers Name	Subscriber's Date of Birth / /	Place of Service
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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 _____ Date ____/____/____

Date of Services / /	<input checked="" type="checkbox"/>	Procedure Code	When "Other" is checked fully describe services or supplies furnished	Charges
/ /		V2020	Frames	
/ /		V2199	Single Vision Lens	
/ /		V2299	Bifocal Lens	
/ /		V2399	Trifocal Lens	
/ /		V2781	Progressive Lens	
/ /		V2599	Contact Lens (List Type)	
/ /		S0500	Disposable Contact Lenses	
/ /			Other Services	
/ /		92002	Routine examination including refraction; new patient	
/ /		92012	Routine examination including refraction; established patient	
/ /		92310	Contact Lens Fitting	

DIAGNOSIS V72.0	ADDITIONAL DIAGNOSIS	Total Charges
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Tax ID Number	National Provider ID	Phone Number ()
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Provider Name

Provider Street Address

City	State	Zip Code
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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 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 South Dakota, PO Box 5023, Sioux Falls, South Dakota 57117-5023**. 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.

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.

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 at the number on your insurance identification card.
- 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**
PO Box 5023
Sioux Falls, South Dakota 57717-5023