

PO Box 5023  
Sioux Falls, SD 57117-5023

Patient Name:  
Provider Name:  
Member I.D. #:

Claim #:  
Date of Service:  
Group #:

We have received a claim that may be the result of an accidental injury/illness. You must respond to the following questions:

**Was the injury/illness employment (work) related?**       Yes       No

**If No, do one of the following:**

- Sign and date this form and return it to us by mail.
- Call our Customer Service department at the number printed on your I.D. card.
- FAX the signed and dated form to us at **515-376-9097**

**IF INJURY/ILLNESS WAS WORK RELATED:**

Are you self-employed?       Yes       No

**If Yes, do one of the following:**

- Sign and date this form and return it to us by mail.
- FAX the signed and dated form to us at 515-376-9097.

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**If No:** Describe the injury or illness: \_\_\_\_\_

Employer's name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_

Are you covered by your employer's worker's compensation coverage?       Yes       No

If no, reason? \_\_\_\_\_

Did you report the illness/injury to your employer?       Yes       No

Date of Injury \_\_\_\_\_ Date reported \_\_\_\_\_

Was this claim paid by your workers compensation carrier?       Yes       No \*       Pending

**\* If no, please provide us with a copy of the denial from your worker's compensation insurer.**

If you have retained an attorney for your Workers Compensation injury or illness, please provide us with the following information:

Attorney's name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**Sign & date this form and return to Wellmark by mail or FAX.**

I have answered all questions truthfully and to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Daytime Phone # \_\_\_\_\_ Customer I.D. \_\_\_\_\_