



Wellmark Blue Cross Blue Shield of Iowa
Wellmark Health Plan of Iowa, Inc.

An Independent Licensee of the Blue Cross and
Blue Shield Association

APPEAL 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 and 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 Authorization 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 Explanation of Health Care Benefits or letter of denial or reduction)

Has the service in question already been provided?

Yes

Date of Service(s): _____

Provider Name: _____

Claim Number(s): _____

No

Date of Denial: _____

Provider Name: _____

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. **This appeal 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 5W189
P.O. Box 9232
Des Moines, IA 50306-9232