An Independent Licensee of the Blue Cross and Blue Shield Association

PO Box 9232
Des Moines, IA 50306-9232

AN IMMEDIATE RESPONSE TO THIS QUESTIONNAIRE IS REQUIRED OR YOUR CLAIM(S) WILL NOT BE PROCESSED

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:

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, or fax to us at **515-376-9068**.
Call our Customer Service department at the number printed on your I.D. card.

IF INJURY/ILLNESS WAS WORK RELATED:

Date of Injury ______/______/______

Are you self-employed? ☐ Yes ☐ No

If Yes: Sign and date this form and return it to us by mail, or fax to us at **515-376-9068.**

If No: Describe the illness or indicate the part(s) of the body injured: ______________________

Employer's name ______________________

Employer's Phone # ______________________

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

If No: Reason? ______________________

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

Was this claim paid by your worker's compensation carrier? ☐ Yes ☐ No ☐ Pending

If No: Please provide us with a copy of the denial from your worker's compensation insurer.

If Yes or Pending: Please provide the following information:

Worker's Compensation Carrier Name ______________________

Address ______________________

Phone # ______________________ Claim Number ______________________

Adjuster Name ______________________

If you have retained an attorney for your Worker's 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 to us at 515-376-9068.

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

Signature ______________________ Date ______/______/______

Daytime Phone # ______________________

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