



An Independent Licensee of the Blue Cross and Blue Shield Association

OVERPAYMENT RECOVERY APPEAL FOR CMS-1500 BILLERS

I wish to appeal an overpayment recovery request before the anticipated overpayment recovery is completed. I understand that by requesting an appeal, the recovery will be stopped until Wellmark has made a decision relative to the appeal. I further understand that if the outcome of the appeal indicates that the overpayment request is appropriate, Wellmark will deduct the overpayment from the next remittance following the appeal decision. I understand that I have appeal rights if the recoupment is performed. **Note:** please use the Provider Inquiry form for post-recovery reviews.

Required Provider Information

Provider Name _____ Provider Number _____
Reply Address _____ City _____ State _____ Zip _____
Provider Contact Person _____ Contact Telephone # (____) _____
Provider Fax # (____) _____

Required Member Information

Member ID # Alpha Prefix _____ Member ID# _____ Member Name _____

Required Claim Information

Patient Name _____ Patient Account # _____
Dates of Service ____/____/____, ____/____/____, ____/____/____, ____/____/____ Total Charge \$ _____
Claim ICN # _____ AR # _____
Indicated Overpayment \$ _____ Remittance Date ____/____/____

Is overpayment related to coordination of benefits (other health carrier involved)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Subrogation? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Accident ____/____/____	Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Injury ____/____/____
Wellmark Secondary to Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Double Coverage (two Wellmark policies)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Note: if the claim review requires COB or Medicare information, attach the primary carrier's EOB/MRN. If the claim review requires Workers' Comp/subrogation Information, attach Workers' Comp/subrogation payment or denial information.

Details of Request

Please include any applicable supporting detail and documentation

Date of Request ____/____/____

Send To: Overpayment Recovery Appeal
Wellmark Blue Cross and Blue Shield of South Dakota
Station 363
PO Box 5023
Sioux Falls, SD 57117-5023
Fax: 515-376-9098