Wellmark Blue Cross and Blue Shield of South Dakota is an Independent Licensee of the Blue Cross and Blue Shield Association.

Send to:
Provider Service Center Station 347
Wellmark Blue Cross and Blue Shield of South Dakota
1601 West Madison Street
Sioux Falls SD 57104

Provider Inquiry

Required Information

Inquiries with incomplete information will be returned to the provider.

Provider Name ______________________________ Provider Number ____________________
Reply Address ____________________ City ________________ State _______ Zip _________
Provider Contact Person ____________________ Contact Telephone Number (_____)___________
Provider Fax Number (optional) (_____)____________________ Reply by Fax ☐ Yes ☐ No

Member Identification Number Alpha Prefix ____________ Member ID# ______________________
Member Name ________________________________
Patient Name ____________________________ Patient Account Number __________________
Date(s) of Service ____/____/____, ____/____/____, ____/____/____, ____/____/____
MM / DD / YY MM / DD / YY MM / DD / YY MM / DD / YY

Total Charge ______________________
Claim/ICN Number ____

Reason for Inquiry Request - Check all that apply

Please include a copy of provider remittance report and a copy of the corrected claim when applicable.

☐ Corrected claim - submit entire claim with corrections
Specify________________________________
☐ Claim Status (if no web access)
☐ Duplicate Denial in Error

☐ Review Denied Claim
Message/Denial code, if Present __________
☐ Underpayment/Payment Allowance Review
☐ Overpayment

Other Coverage

Workers' Compensation ☐ Yes ☐ No Date of Injury ____/____/____
Coordination of Benefits (other health insurance carrier involved) ☐ Yes ☐ No
Subrogation ☐ Yes ☐ No Date of Accident ____/____/____

☐ Wellmark Secondary to Medicare

☐ Double Coverage (Blue on Blue)

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

Date of Request ____/____/____

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Supporting Documentation

When submitting claim for review, please attach the required documentation which may include:

- office notes
- physical medicine/chiropractic notes
- Pharmacy
  - NDC number
  - quantity
  - description of service/drug
- operative report(s)
- HME (home medical equipment)
  - include provider manufacturer's invoice if requesting additional allowance

* see reverse side for definitions and helpful hints.

Definitions

Reply Address- The mailing address where the reply to this inquiry should be sent.

Member- The person whose name the health coverage is under.

Claim/ICN Number- A 14-digit internal control number (ICN) Wellmark uses to identify each claim.

Patient Account Number- Any recordkeeping number up to 10 alphanumeric characters assigned to a patient's medical information by a practitioner/facility.

Total Charge- The total amount of ALL charges that were included on this billing.

Helpful hints

- Use one provider inquiry form per patient per issue
- Use the provider inquiry form when you are asking for review or adjustment of a previously processed claim and you need to submit supporting documentation for the review.