



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

Independent Licensees of the Blue Cross and  
Blue Shield Association

Send to:  
Provider Service Center Station 5C139  
Wellmark Blue Cross and Blue Shield of Iowa  
PO Box 9232  
Des Moines IA 50306-9232

# Provider Inquiry

## Required Information

Inquiries with incomplete information will be returned to the provider.

Provider Name \_\_\_\_\_ Provider NPI \_\_\_\_\_  
 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)

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)  Review Denied Claim  
 Message/Denial code, if Present \_\_\_\_\_

Duplicate Denial in Error  Underpayment/Payment Allowance Review

**Other Coverage**  
 Workers' Compensation  Yes  No Date of Injury \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Coordination of Benefits (other health insurance  Overpayment  
 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

## 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.