

Medical/Surgical Prior Approval (Pre-service Inquiry)

An Independent Licensee of the Blue Cross and Blue Shield Association

Patient Name (Last, First, Middle Initial)		Certificate Holder Identification Number		Patient's Date of Birth / /	
Certificate Holder Name (Last, First, Middle Initial)		Patient's Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Certificate Holder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		Provider NPI#
Address		Provider Telephone Number		Provider Fax Number	
City, State, Zip Code		Diagnosis			
Provider Name (Last, First, Middle Initial)		Diagnosis Code			
Address		Additional Information (Attach medical necessity documentation as necessary.) _____			
City, State, Zip Code					

Services To Be Approved

Anticipated Date of Service	CPT/HCPC Codes	Description of Service	DME Charge	DME Allowance
/ /				
/ /				
/ /				

I certify the accuracy and completeness of all information reported by me on this form.

Provider Signature _____ Date ____/____/____

Other _____

Outcome

Medically Approved: _____
 Effective Dates of Approval: From ____/____/____ to ____/____/____
 Other Limitations of the Approval: _____

Denied, Not a Contract Benefit

Denied Cosmetic Investigational

This decision is for the procedures or services identified above and is subject to the following conditions:

- Approval is granted on the basis of the terms of the contract that provides benefits for this patient that is in effect on the date of the approval. If, for any reason, the patient's coverage should change before the service is provided, other limitations will apply and you should contact Wellmark for verification of membership.
- Payment for the above service(s), will be limited by the maximum allowable fees in effect for this service on the date the service is performed and limited by any benefit maximum amounts provided in the contract. The member may be responsible for charges in excess of the payment. Financial responsibilities should be discussed before the service is provided.
- If the member's contract requires a referral, precertification, preprocedure review or second opinion, these must be obtained prior to admission to the hospital or before the service is provided. Failure to do so may result in a benefit reduction or denial of benefits.
- If you need an extension to the effective dates indicated above, please contact Wellmark.
- Additional questions should be directed to Wellmark's Provider or Customer Service.

Additional Information

- You have a right to obtain a copy of the actual benefit provision, guideline, medical policy, or other criteria on which denial decision was based. Please submit your written request to the address below.
- If the denial decision was based upon Wellmark's medical policy or medical necessity criteria, your provider may contact Provider Service and request to discuss the case with Wellmark's physician reviewer.
- You may request an appeal of this decision. Please refer to the enclosed How to Appeal and ERISA Rights document for further information.

Wellmark Signature _____ Date ____/____/____

Provider: Please complete this form and submit it to Wellmark at one of the addresses or fax numbers given below.

Wellmark Blue Cross and Blue Shield of South Dakota
 Prior Approval Unit - Mail Station 5W198
 PO Box 9232
 Des Moines, Iowa 50306-9232
 Fax: 515-376-9016