Clear Form

Provider Inquiry

Wellmark South Dakota

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

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 ____/____/____

_____

_____

_____

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.