

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 1E238 Wellmark Blue Cross and Blue Shield of Iowa PO Box 9232 Des Moines IA 50306-9232

Fax to: 515-376-9068

Provider Inquiry

Inquiries with incom	Required Informat plete information will be	tion e returned to the provider.		
Provider Name	Provider NPI			
Reply Address				
Provider Contact Person	=			
Provider Fax Number (optional) ()		Reply by Fax	□No	
Member Identification Number Alpha Prefix _	Mo	ember ID#		
Member Name				
Patient Name	Patient /	Account Number		
Date(s) of Service//,,	//			
Total ChargeClaim/ICN Number				
Please include a copy of provider rem Corrected claim - submit entire claim with corre	ctions		hen applicable.	
Specify		Deview Devied Claim		
Claim Status (if no web access)	_	Review Denied Claim Message/Denial code, if Present		
☐ Duplicate Denial in Error Other Coverage		Underpayment/Payment Allowance Review		
	_	onderpayment/Payment And	owance Review	
Workers' Compensation Yes No Date of Inju Coordination of Benefits (other health insurance	=	Overpayment		
carrier involved) Yes No	Ш	Overpayment		
Subrogation Yes No Date of Accident	1 1			
Wellmark Secondary to Medicare	//			
Double Coverage (Blue on Blue)				
Note: If the claim review requires COB or Medicare infor Comp/Subrogation information, attach Workers' Comp/S			im review requires Workers'	
	Details of Reque	st Date of Re	equest/	

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.