



Member Submitted Claim Form

Thank you for being a member of Wellmark Blue Cross and Blue Shield. Please review the instructions below for helpful information on how to submit your claim so it processes quickly and accurately. **Note:** *All fields on this form are required in order to be processed correctly. Incomplete claim forms will not be processed. Complete the form using a blue or black pen. Please do not use highlighters.*

This claim form is for health care services received inside the United States. If services were provided outside the U.S., please use the [Blue Cross and Blue Shield Global™ Claim Form](#). For prescription drugs, please use the [Prescription Reimbursement Claim Form](#).

Member Instructions - Section 1

1. Complete section 1 and sign the form. Ask your physician or health care provider to complete section 2.
2. Submit a separate claim form for each family member and each provider of health care service. Retain copies of all documents for your records.
3. Submit completed form (section 1 and 2) and any receipts and itemized statements to: Wellmark Blue Cross and Blue Shield - Mail Station 1E238 - PO Box 9291 - Des Moines, IA 50306-9291

Please file your claim as soon as possible after receiving care. For specific filing deadlines refer to the Claims section of your Wellmark Coverage Manual for more details. If you have questions or need assistance go to [Wellmark.com](#) or call Customer Service at the phone number shown on the back of your Wellmark ID card.

Physician/Provider Instructions - Section 2

1. Complete section 2 and sign form.
2. Return completed form to the policy holder/patient or mail it to the address listed above on the patient's behalf.

Section 1 - Member	ID Card Information		Patient Information (if different from Policyholder)				
	Policyholder's Identification Number on ID Card: (include any letters) _____		Patient First Name:		Patient Last Name:		
	Policyholder's Name on ID Card: (first name, middle initial, last name)		Patient's Date of Birth: ____/____/____				
	Policyholder's Date of Birth: ____/____/____		Patient's Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other				
	Policyholder's Address: _____ _____		Patient's Address: (if different from Policyholder) _____ _____				
	I certify that the information given is complete and correct, and that I am claiming benefits only for charges incurred by the patient named above. Policy/Certificate Holder's Signature: _____ Date: ____/____/____						
Section 2 - Provider	Services and Provider of Service Information - To be filled out by the Provider						
	For services related to hospitalization or long-term care facility please provide the following: Admission Date: ____/____/____ Discharge Date: ____/____/____						
	From Date of Service MM/DD/YYYY	To Date of Service MM/DD/YYYY	HCPCS/CPT/ADA Code including Modifier	Description of Service/Supply	Diagnosis Code	Charges	Days or Units
						\$	
						\$	
						\$	
						\$	
						\$	
	Total amount billed/charged:					\$	
	Amount paid by member:					\$	
Provider of Service Name:			Tax ID:		Billing NPI:		
Address (location where services were provided):			City, State and ZIP:		Place of Service: ☐ Inpatient ☐ Outpatient ☐ Office ☐ Other _____		
Referring/Rendering Provider Name:			Referring/Rendering Provider NPI:				
I certify these services were performed by me or in my presence under my supervision. Provider of Service Signature: _____ Date: ____/____/____							

Wellmark Language Assistance

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Wellmark does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Wellmark

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email CRC@Wellmark.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobu oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم (٢٦٢٤-١٨٧-٨٨٨) أو (خدمة الهاتف النصي: ٢٤٢٩-٤٢٥-٠٠٨).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ ໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ. (TTY: 888-781-4262).

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें: अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION: Si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deutsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิด ค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyon sa tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တရားဝင်ပြောဆိုမှုကိစ္စများကို ကူညီပေးရန်အတွက် အခမဲ့ဘာသာစကား အကူအညီဝန်ဆောင်မှုများကို ၈၀၀-၅၂၄-၉၂၄၂ (TTY: ၈၈၈-၇၈၁-၄၂၆၂) နှင့် ဆက်သွယ်ပါ။

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: ከግርግር ግሚና፣ ከሆነ፣ የቋንቋ አገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም በ(TTY: 888-781-4262) ደውለው ያነጋግሩ።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maada. Hebir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnaama.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojí' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)