



Wellmark Provider Refund/Overpayment Inquiry

* Required Fields

Provider Information		
Name*:	Tax ID*:	National Provider Identifier (NPI)*:
Contact Name*:	Phone Number* (Including area code):	
Iowa Providers, mail this form with check attached to: Claims Financial Mail Station 4W675 Wellmark Blue Cross and Blue Shield of Iowa PO Box 9232 Des Moines, IA 50306-9232	South Dakota Providers, mail this form with check attached to: Accounting Station 333 Wellmark Blue Cross and Blue Shield of South Dakota PO Box 5023 Sioux Falls, SD 57117-5023	

Member/Patient Information	
☐ FEP Member ☐ Wellmark Member ☐ Out of State BCBS Member	Member Name*:
Member ID* (Including alpha prefix)	Patient Name* (If different than Member)
Total Check Amount*:	Check Number*:

Claims/Overpayment Information
Overpayment reason* (select one and must be the same for all claims listed): ☐ Inquiry submitted; Wellmark instructed provider to send in check; reference correspondence # _____ ☐ Claim could not be adjusted as it exceeds Wellmark's adjustment timeliness guidelines ☐ Outstanding Accounts Receivable (AR) # _____ not auto recouped ☐ Wellmark Representative contacted Provider directly for return of funds. Provide details below: (Include reason for returning funds, name and contact information of Wellmark Representative, etc.) ☐ Other; Provider details below: (Include all pertinent details regarding this manual check)

Enter claims details. List up to 5 claims for the same patient and reason		
Claim Number*:	Date of Service*: ____/____/____	Refund Amount*:
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