Wellmark

Wellmark Blue Cross and Blue Shield of Iowa and Blue Shield of South Dakota are independent licensees of the Blue Cross and Blue Shield Association

WELLMARK MEMBER APPEAL FORM

This form is for Wellmark Members or their Authorized Representative to request a review of a claim or prior authorization determination.

PLEASE PRINT OR TYPE ALL INFORMATION

Member Information

Required fields are identified with an Asterisk *

Member Name*:_____ **Member Wellmark ID*:**_____

Patient Name*:_____ **Phone Number:**_____

Mailing Address*:_____

Email Address:_____

Appeal Type & Date

Appeals must be submitted to Wellmark within 180 days from the date the Explanation of Health Care Benefits was issued, the date pre-service denial letter was issued, or notice of adverse benefit determination. *Providers or other designated authorized representatives submitting Appeals on behalf of a Member must complete the Requestor Information section of this form and obtain the Member's signature authorizing the Provider of other designated authorized representative to act as their Personal Representative. Appeals submitted without this authorization will not be processed.*

☐ Pre-Service Reference Number (if applicable):_____ Date of Denial:_____/_____/_____

☐ Claim Number(s)**:_____

Date(s) of Service:_____

***Include all claim numbers related to this appeal below*

For the most accurate review:

- Provide a clear explanation of your appeal.
- Specify the action you are requesting.
- Use additional sheets if more space is needed.
- Attach any supporting documentation that may assist in our review, such as medical records, provider chart notes, or other relevant materials.

You will receive a written response to your request within the time required by law.

Member or Authorized Representative Signature[1]:_____

Date of Signature: _____/_____/_____

Submitter Printed Name:_____

[1]If this is being signed by anyone other than the Member - page 2 must be completed.

Mail to: Wellmark Blue Cross and Blue Shield, Special Inquiries and Appeals, PO Box 9232, Des Moines, IA 50306-9232
Or Fax to: 515-376-9073

Appeals Personal Representative Appointment and Authorization to release protected health information

Personal Representative Information

If you are requesting an appeal on behalf of a member as an Authorized Representative, all fields in this section are required, including the Member's Signature. If you are a Member requesting an Appeal on your own behalf, you may skip this section.

This Appeal is being requested by (Full Name):_____

Mailing Address:_____ **Suite/Unit Number:**_____

Email Address:_____

Phone Number:_____

Relationship with Member: ☐ Provider ☐ Power of Attorney ☐ Parent or Legal Guardian

Provider NPI (If relationship is Provider)**:**_____

PERSONAL REPRESENTATIVE APPOINTMENT

I appoint the individual named above to act on my behalf as my Authorized Personal Representative with Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., Wellmark Synergy Health, Inc., Wellmark Value Health Plan, Inc., or Wellmark Blue Cross and Blue Shield of South Dakota (collectively, "Wellmark") in connection with my appeal of a benefit determination.

Effective: This appointment of Authorized Personal Representative granting authorization to disclose is effective upon Wellmark's receipt of a fully completed and signed original or exact copy of this form.

Expiration: This appointment and authorization will expire 30 days after termination of my health plan coverage or upon settlement of this Appeal, unless revoked by me at my request.

Right to Revoke: I understand that I may revoke this appointment and authorization at any time by giving written notice of my revocation to Wellmark at the address stated below. I understand that revocation of this appointment and authorization will not affect any action Wellmark took in reliance on this appointment and authorization before Wellmark received my written notice of revocation.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Protected Health Information to be Disclosed: I authorize Wellmark to disclose the protected health information described in this form to the named Authorized Personal Representative.

This authorization shall include and apply to any and all protected health information related to treatments where the individual has requested a restriction and/or for any health care item or service for which the health care provider has been paid out of pocket in full.

Effect or Granting this Authorization: I understand that if the person or entity that receives the information requested is not covered by federal or state privacy laws, the information described above may be redisclosed and will no longer be protected by law.

Prohibition on Redisclosure: This form does not authorize the disclosure of medical information beyond the limit of the authorization. Where information has been disclosed from the records protected by Federal law for alcohol/drug abuse records or state law for mental health records, the Federal requirements (42 CFR Part 2) and state requirements (Iowa Code Chapter 228 or South Dakota Codified Laws Chapter 27A-12) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

No Conditions: I understand this authorization is voluntary and Wellmark will not condition my enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Continued on next page

Specific Authorization for Mental Health, Substance Abuse Treatment or AIDS-Related Information

I authorize and consent to the release and disclosure of any and all protected health information, as described in this form, including specifically mental health information, substance abuse (drug or alcohol), and AIDS-related information, if applicable, to the individual named as long as this appointment of Authorized Representative is in effect. I understand that I may inspect the mental health information disclosed.

I have had full opportunity to read and consider the contents of this personal representative appointment and authorization, and I understand that, by signing this form, I am confirming authorization of the disclosure of my protected health information, as described in this form. If this authorization involves the disclosure of mental health information, I acknowledge receipt of a copy of the authorization.

Member Signature (or Legal Guardian if applicable)**:**_____

Date of Member Signature: _____/_____/_____

Print Name of Legal Guardian* (if applicable)**:**_____

**If a legal guardian signs for an individual, a copy of the guardian appointment document must be submitted with this form.*

RETAIN A COPY FOR YOUR RECORDS

Send completed and signed for to:
Wellmark Blue Cross and Blue Shield
Special Inquiries and Appeals
PO Box 9232
Des Moines, IA 50306-9232

OR

Fax to: 515-376-9073

Wellmark®

Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc. and Wellmark Blue Cross and Blue Shield of South Dakota are independent licensees of the Blue Cross and Blue Shield Association.

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 osobe 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 ٨٠٠-٥٢٤-٩٢٤٢ أو (خدمة الهاتف النصي: ٨٨٨-٧٨١-٤٢٦٢).

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

주의: 한국어 를 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 Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

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

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

တၢ်ဒုးသ့ၣ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်,ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖၣ်,လၢတဘၣ်လၢာ်ဘူးလဲ,အိၣ်လၢနဂီၢ်လီၤ.ဆဲးကျိးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

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፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይደውለው ያነጋግሩን።

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

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

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, náhóló̜. Koj̨' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)