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

Policyholder's Identification Number on ID Card:
(include any letters)

___ _____

Policyholder's Name on ID Card: (first name, middle initial, last name)

Policyholder's Date of Birth: ____/____/____

Policyholder's Address:

_____

_____

Patient Information (if different from Policyholder)

Patient First Name:

Patient Last Name:

Patient's Date of Birth: ____/____/____

Patient's Relationship to Policyholder:
☐ Self ☐ Spouse ☐ Child ☐ Other

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: Heartland Endocrine Group	Tax ID: 83-2149529	Billing NPI: 1710908181
Address (location where services were provided): 4620 East 53rd St. Suite 200	City, State and ZIP: Davenport, IA 52807	Place of Service: ☐ Inpatient ☐ Outpatient ☑ Office ☐ Other_____
Referring/Rendering Provider Name: Mary Kathleen Figaro, MD	Referring/Rendering Provider NPI: 1710908181	

I certify these services were performed by me or in my presence under my supervision.

Provider of Service Signature: _____ Date: ____/____/____

 I have already paid. Please make check payable to me.