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

Required Information

Inquiries with incomplete information will be returned to the provider.

Provider Name _____ Provider NPI _____
Reply Address _____ City _____ State _____ Zip _____
Provider Contact Person _____ Contact Telephone Number (_____)_____
Provider Fax Number (optional) (_____)_____ Reply by Fax ☐ Yes ☐ No

Member Identification Number Alpha Prefix _____ Member ID# _____
Member Name _____
Patient Name _____ Patient Account Number _____
Date(s) of Service _____/_____/_____, _____/_____/_____, _____/_____/_____, _____/_____/_____
MM / DD / YY MM / DD / YY MM / DD / YY MM / DD / YY
Total Charge _____
Claim/ICN Number _____

Reason for Inquiry Request - Check all that apply

Please include a copy of provider remittance report and a copy of the corrected claim when applicable.

☐ Corrected claim - submit entire claim with corrections
Specify_____
☐ Claim Status (if no web access)
☐ Duplicate Denial in Error
☐ Review Denied Claim
Message/Denial code, if Present _____
☐ Underpayment/Payment Allowance Review
☐ Overpayment

Other Coverage
Workers' Compensation ☐ Yes ☐ No Date of Injury _____/_____/_____
Coordination of Benefits (other health insurance carrier involved) ☐ Yes ☐ No
Subrogation ☐ Yes ☐ No Date of Accident _____/_____/_____
☐ Wellmark Secondary to Medicare
☐ Double Coverage (Blue on Blue)

Note: If the claim review requires COB or Medicare information, attach the primary carrier's EOB/MRN. If the claim review requires Workers' Comp/Subrogation information, attach Workers' Comp/Subrogation payment or denial information.

Details of Request

Date of Request _____/_____/_____

_____
_____
_____

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.

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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.