Wellpoint

Claim Correspondence – Submission Form

This form should be completed by providers for claim correspondence only.

Member information

Member First/Last Name: _____ Member Date of Birth: _____

Member Coverage: ☐Medicaid ☐Medicare

Member ID: _____

Provider/Provider Representative information

Provider First/last name: _____

Provider street address: _____

City: _____ State: _____ Zip code: _____ Phone: (___)_____

National Provider Identification Number: _____

Select one: ☐ I am a participating provider. ☐ I am a nonparticipating provider.

Provider Representative: ☐ Self ☐ Billing Agency ☐ Law Firm ☐ Other: _____

Representative Contact Name: _____ Contact Phone _____

Representative Street Address: _____

City: _____ State: _____ Zip code: _____

Claim information*

Claim number: _____ Billed amount $: _____ Amount received: _____

Start date of service: _____ End date of service: _____ Authorization number: _____

* If you have multiple claims related to the same issue, you can use one form and attach a listing of the claims with each supporting document following behind.

Claim Correspondence
Claim correspondence is defined as a request for additional/needed information in order for a claim to be considered clean, to be processed correctly, or for a payment determination to be made.

To ensure timely and accurate processing of your request, please complete the section below by checking the applicable category your correspondence applies to.

☐ Itemized bill	☐ Sterilization consent form	☐ Hysterectomy consent form
☐ Abortion consent form	☐ Invoice	☐ Medical records
☐ Corrected claim	☐ Other health insurance information	☐ Other: _____
☐ ER Level of Payment Review		

Mail this form, a listing of claims (if applicable), and supporting documentation to:

Claim Correspondence
Wellpoint
P.O. Box 61599
Virginia Beach, VA 23466-1599