MEMBER PAID CLAIM
SUBMISSION FORM

WellFirst Health™

INSTRUCTIONS:

1. One form per member.
2. One form per date of service/date of occurrence.
3. Fill out the form completely—items left blank may prevent or delay the timely processing of your claim.
4. Include a paid receipt for all services. Services listed on the form, but for which there is no receipt, will result in denial of the claim.
5. Include an invoice with all needed information listed including the Name of the facility that you were seen at—member seen, procedure code, diagnosis code, place of service code, amount billed for each procedure code, modifier(s), quantity of each service.

Member ID Number:	Member Last Name:	Member First Name:
Date of Occurrence:	Name of Facility/Doctor:	Total Refund Requested:

Reason for Treatment (i.e. what illness/injury occurred):

Location Services Received (e.g. emergency visit @ St. Mary's Hospital):

Type of Service Received (i.e. x-ray of right leg, acupuncture, etc.):

Diagnosis Code(s):		Place of Service Code:	
Procedure Code:	Price:	Modifier:	Quantity:
Procedure Code:	Price:	Modifier:	Quantity:
Procedure Code:	Price:	Modifier:	Quantity:
Procedure Code:	Price:	Modifier:	Quantity:
Procedure Code:	Price:	Modifier:	Quantity:

Mail completed form with receipts to:

WellFirst Health • PO Box 56099 • Madison, WI 53705

or fax completed form with receipts to: ATTN: Claims 608-836-1210