

Provider / Doctor Claim Inquiry

INSTRUCTIONS

IMPORTANT: This form will not be accepted for review of *NC provider appeals*

- Use this form to request review of a previously adjudicated claim
- Submit only **one form per member**
- New or corrected claims should be submitted directly to the plan electronically or by mail if you are not an electronic biller. Faxed claims are not accepted
- Inquiries received without the required information below or completed in its entirety will not be reviewed or processed
- Out of state provider appeals, see home plan policies

FOR PROVIDER USE ONLY

To help expedite your review, please complete this form in its entirety:

PLEASE MAIL ALL INQUIRIES TO:
 BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA
 P.O. BOX 2291
 DURHAM, NC 27702

Please Fax to:
 1-866-987-4167

*Indicates a required field

PROVIDER INFORMATION

CLINICAL INFORMATION

*PROVIDER NAME		*CLAIM NUMBER
*PROVIDER MAILING ADDRESS		*TOTAL CHARGE
*CITY/STATE	*ZIP CODE	*TO-DATE OF SERVICE
*INDIVIDUAL NPI NUMBER	*GROUP NPI NUMBER	*FROM-DATE OF SERVICE

MEMBER INFORMATION

*MEMBER NAME	*MEMBER DATE OF BIRTH
*SUBSCRIBER ID WITH ALPHA PREFIX	MEMBER ACCOUNT NUMBER

*TYPE OF REVIEW

(You must check one of the following)

Please note: In an effort to support compliance with the Paperwork Reduction Act (44 U.S.C. 3501 et seq.) we are requesting the minimal records. However, if the requested information does not support reimbursement for the claim, please send any additional information necessary to support the claim as originally submitted.

The reason for this inquiry is:

Claim(s) Inquiry

- Original claim denied for timely filing (proof of timely filing attached)
- Original claim denied or closed for "coordination of benefits"
- Original claim denied for no authorization but valid authorization on file
- Claim denied as duplicate to a previously finalized claim
- Original claim denied no coverage
- Newborn added to policy, original claim denied
- Incorrect member name/ID billed on previously submitted claim
- Incorrect copay/coinsurance applied benefit quoted was not received
- Overpayment/underpayment due to another payer (COB)
- Contractual allowance dispute (fee schedule documentation required)

Special Investigations (submit a copy of the inquiry form, the claim and all supporting medical records must be attached)

Medical Records - Reconsideration of a previously adjudicated claim related to:

* Only use for **out of state** member submissions

- medical necessity
- potentially cosmetic, experimental or investigational services

Medical Records - Upfront submission of supporting medical records in advance of claim(s) being processed

- proactive medical records