Provider / Doctor Claim Inquiry

This form can be mailed to **Blue Cross NC, PO Box 2291, Durham NC 27702 or faxed to 919-765-1920**. This form will not be accepted for NC provider appeals.

Provider Information

TELEPHONE NUMBER	FAX NUMBER
GROUP PROVIDER NUMBER	**INDIVIDUAL PROVIDER NUMBER**

TO: _____

_____

_____

FROM: _____

_____

_____

Same Patient Information

PATIENT NAME

CERTIFICATE HOLDER

SUBSCRIBER ID WITH ALPHA PREFIX

DATE OF SERVICE

TOTAL CHARGE

Place of Service

☐ Office ☐ Ambulatory surgical center ☐ Inpatient facility ☐ Outpatient facility

Program

☐ HMO ☐ BlueCard®
☐ PPO ☐ Blue Advantage®
☐ SHP – PPO ☐ Federal Employee Program

The reason for this inquiry is:

1. ☐ New Claim
2. ☐ Corrected Claim
3. ☐ Claim(s) Status ☐ **Blue *e*** SM claim status has been reviewed
4. ☐ Underpayment
   a. Patient's other coverage paid ..... $ _____
   b. Payment was made by:
      Name of company _____
      Name of the group _____
      Name of Insured _____
   c. Possible underpayment of..... $ _____
5. ☐ Medical Records - Reconsideration of a ***previously processed*** claim related to:
   a. ☐ coding / bundling ☐ Clear Claim Connection supporting documentation included
   b. ☐ medical necessity
   c. ☐ potentially cosmetic, experimental or investigational services
   d. ☐ pricing
   e. ☐ pre-existing
   f. ☐ special investigations (submit a copy of the inquiry form, the claim and all supporting medical records must be attached)
6. ☐ Medical Records - Submission of solicited medical records for a pending claim related to:
   a. ☐ medical necessity
   b. ☐ pre-existing
   c. ☐ pricing
   d. ☐ potentially cosmetic, experimental or investigational services
7. ☐ Medical Records submitted for other reasons:
   Explanation: _____

_____

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