

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		Same Patient Information
TELEPHONE NUMBER	FAX NUMBER	PATIENT NAME
GROUP PROVIDER NUMBER	INDIVIDUAL PROVIDER NUMBER	CERTIFICATE HOLDER
TO: _____ _____ _____ FROM: _____ _____ _____ _____		SUBSCRIBER ID WITH ALPHA PREFIX
		DATE OF SERVICE
		TOTAL CHARGE
		Program <input type="checkbox"/> HMO <input type="checkbox"/> BlueCard® <input type="checkbox"/> PPO <input type="checkbox"/> Blue Advantage® <input type="checkbox"/> SHP – PPO <input type="checkbox"/> Federal Employee Program
Place of Service <input type="checkbox"/> Office <input type="checkbox"/> Ambulatory surgical center <input type="checkbox"/> Inpatient facility <input type="checkbox"/> Outpatient facility		
The reason for this inquiry is: 1. <input type="checkbox"/> New Claim 2. <input type="checkbox"/> Corrected Claim 3. <input type="checkbox"/> Claim(s) Status <input type="checkbox"/> Blue eSM claim status has been reviewed 4. <input type="checkbox"/> Overpayment / Underpayment a. Patient's other coverage paid \$ _____ b. Payment was made by: Name of company _____ Name of the group _____ Name of Insured _____ c. Possible overpayment / underpayment of \$ _____ 5. <input type="checkbox"/> Medical Records - Reconsideration of a <i>previously processed</i> claim related to: a. <input type="checkbox"/> coding / bundling <input type="checkbox"/> Clear Claim Connection supporting documentation included b. <input type="checkbox"/> medical necessity c. <input type="checkbox"/> potentially cosmetic, experimental or investigational services d. <input type="checkbox"/> pricing e. <input type="checkbox"/> pre-existing f. <input type="checkbox"/> special investigations (submit a copy of the inquiry form, the claim and all supporting medical records must be attached) 6. <input type="checkbox"/> Medical Records - Submission of solicited medical records for a pending claim related to: a. <input type="checkbox"/> medical necessity b. <input type="checkbox"/> pre-existing c. <input type="checkbox"/> pricing d. <input type="checkbox"/> potentially cosmetic, experimental or investigational services 7. <input type="checkbox"/> Medical Records submitted for other reasons: Explanation: _____ _____ _____		