Provider / Doctor Claim Inquiry

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**℠ claim status has been reviewed
4. ☐ 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. ☐ 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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