

Additional Information Form

Additional Information requested may be submitted with the letter received or this form.

DO NOT USE THIS FORM UNLESS YOU HAVE RECEIVED A REQUEST FOR INFORMATION.

Original Claims should not be submitted with this form.

Submit only one form per patient.

*****Inquiries received without the required information below may not be reviewed.*****

Claim Number:			<i>(For multiple claims, provide the additional claim number below)</i>
Group Number:	Prefix (3 character alpha):	Member Identification Number:	
Patient Name: <i>(Last, First)</i>			
Date(s) of Service:	Total Billed Amount:		
Provider Name:	NPI:		
Contact Person:	Phone Number:		
Additional Information requested:			
REMINDERS			
<ul style="list-style-type: none"> Mail inquiries to: Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044 Claim Review requests: If you did not receive a letter requesting additional information but are requesting a review of a previously adjudicated claim, use the Claim Review Form on the Forms page of our Provider website, bcbstx.com/provider. Corrected Claim requests should be submitted as electronic replacement claims, or on a paper claim form along with a Corrected Claim Form. This form is online at bcbstx.com/provider. <p>To view claim status online, use the Claim Status Tool on Availity® Essentials at availity.com.</p>			