BlueCross BlueShield of Illinois

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:		***(For multiple claims provide additional claim number below)***
Group Number:	Prefix *(3 character alpha)*:	Member Identification Number:
Patient Name: *(Last, First)*		
Date(s) of Service:		Total Billed Amount:
Provider Name:		NPI:
Contact Person:		Phone Number:
Additional Information requested:		

REMINDERS

- **Mail inquiries to:** Blue Cross and Blue Shield of Illinois
  P.O. Box 805107
  Chicago, IL 60680-4112
- **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 located at bcbsil.com/provider.
- **Corrected Claim requests** should be submitted as electronic replacement claims, or on a paper claim form along with a Corrected Claim Review Form available on our website at bcbsil.com/provider.

To view Claim Status online utilize the Claim Status Tool on the Availity® Provider Portal at availity.com.