



## Provider Claims Inquiry or Dispute Request Form

This form is for all providers requesting information about claims status or disputing a claim with Blue Cross and Blue Shield of Illinois (BCBSIL) and serving members in the state of Illinois. For additional information and requirements regarding provider claim disputes please refer to the Blue Cross Community Health Plans<sup>SM</sup> (BCCHP<sup>SM</sup>) and Blue Cross Community MMAI (Medicare-Medicaid Plan)<sup>SM</sup> (MMAI) Provider Manuals.

Please return this completed form and any supporting documentation to:

**By Mail:** Blue Cross Community Health Plans  
C/O Provider Services  
PO Box 4168  
Scranton, PA 18505

**By Fax:** Alternatively, you may fax this completed form and supporting documentation to the fax numbers provided in Sections 1 and 2 below.

**Providers, please complete the appropriate section based on the below questionnaire for timely processing. All information requested in Sections 1 and 2 are required for processing.**

<b>PROVIDER QUESTIONNAIRE</b>	
1) Have you received a payment remittance (paper or electronic) for this claim?	<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>
2) If you answered "NO" to question #1, please complete <b>Section #1</b> .	
3) If you answered "YES" to question #1, are you disputing the outcome of the claim adjudication?	
<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>	
4) If you answered "YES" to question #3, please complete <b>Section #2</b> .	
5) Please check the below as applicable:	
<input type="checkbox"/> <b>Blue Cross Community MMAI</b>	<input type="checkbox"/> <b>Blue Cross Community Health Plans</b>
<input type="checkbox"/> Contracted Provider	<input type="checkbox"/> Non-contracted Provider
6) <b>Total Number of Faxed Pages Attached to this Form (Including Cover Sheet)</b> _____	

<b>SECTION 1: CLAIM STATUS INQUIRY</b>			
Fax #: 855-756-8727		Processing Time: 10 Business Days	
Claim/EDI Tracking Number(s)		Member ID#	
Member Name*		Date(s) of Service	
Provider Name		Billed Charges (\$)	Contact Person
Provider ID (TIN)	NPI	Provider Phone #	Provider Fax #

\*A separate form must be completed for each Member

## SECTION 2: CLAIM DISPUTE

Fax #: 855-322-0717

Processing Time: 30 Business Days

Claim Number(s)		Member ID#	
Member Name*		Date(s) of Service	
Provider Name		Billed Charges (\$)	Contact Person
Provider ID (TIN)	NPI	Provider Phone #	Provider Fax #

\*A separate form must be completed for each Member

### CATEGORY OF CLAIM DISPUTE

Based upon the following reason(s), Provider requests reconsideration of this claim.  
Provider: Please check applicable reason(s) and attach all supporting documentation

<input type="checkbox"/> <b>Member:</b> Processed under incorrect member	<input type="checkbox"/> <b>Provider:</b> Processed under incorrect provider/tax ID number
<input type="checkbox"/> <b>Coding/Bundling Edits:</b> Attach supporting documentation/ medical records (Documentation is required)	<input type="checkbox"/> <b>Timely Filing:</b> Attach claims and supporting documentation showing claim was filed to Blue Cross Blue Shield of IL in a timely matter
<b>Coordination of Benefits Information:</b> <input type="checkbox"/> Alternate Insurance Information/EOP Attached <input type="checkbox"/> COB – Related Adjustment Primary Insurance	<input type="checkbox"/> <b>Payment Amount:</b> _____ <input type="checkbox"/> <b>Claims Reversal Needed</b> Reason: _____
<b>PLEASE NOTE:</b> This form is for claim payment disputes related to reimbursement rate or processing. This form is <b>NOT intended for requests related to clinical reviews</b> for medical necessity determinations in the case of a denied authorization or retrospective review request.  To request a Service Authorization Dispute (medical necessity) please utilize the following link: <a href="https://www.bcbsil.com/pdf/network/medicaid_service_authorization_dispute_form.pdf">https://www.bcbsil.com/pdf/network/medicaid_service_authorization_dispute_form.pdf</a>	<input type="checkbox"/> <b>Under/Overpayment</b> – Explain the reasoning: _____
	<input type="checkbox"/> <b>Service is not a duplicate</b> – Explain the reasoning: _____
	<input type="checkbox"/> <b>Pre-Authorization now on file</b> – # _____
Comments/Other:	
For Internal Use Only: Resolution: _____ _____ _____	

**CONFIDENTIALITY NOTICE:** This communication, including any attachments, contains confidential information that may be privileged. The information is intended only for the use of the individual(s) or entity to which it is addressed. If you are not the intended recipient, any disclosure, distribution or the taking of any action in reliance upon this communication is prohibited and may be unlawful. If you have received this communication in error, please notify the sender immediately via telephone at the above phone number and destroy the original documents. Thank you.