BlueCross BlueShield of Illinois

Provider Claims Inquiry or Dispute Request Form

Providers serving members in the state of Illinois may use this form to request information about claim status or dispute a claim with Blue Cross and Blue Shield of Illinois. For additional information and requirements regarding provider claim disputes, refer to the provider manual for Blue Cross Community Health Plans℠.

Please return this completed form and any supporting documentation to:

By mail: Blue Cross Community Health Plans
C/O Provider Services
PO Box 650712
Dallas, TX 75265-0712

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.

PROVIDER QUESTIONNAIRE

1) Have you received a payment remittance (paper or electronic) for this claim? ☐ **YES** ☐ **NO**
2) If you answered "NO" to question #1, please complete **Section #1**.
3) If you answered "YES" to question #1, are you disputing the outcome of the claim adjudication?
   ☐ **YES** ☐ **NO**
4) If you answered "YES" to question #3, please complete **Section #2**.
5) Please check the below as applicable:
   ☐ **Blue Cross Community Health Plans** ☐ Non-contracted provider
   ☐ Contracted provider
6) **Total number of faxed pages attached to this form (including cover sheet)** _____

SECTION 1: CLAIM STATUS INQUIRY

Fax #: 855-590-5690 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

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SECTION 2: CLAIM DISPUTE

Fax #: 855-590-5690 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 reasons and attach all supporting documentation

☐ **Member:** Processed under incorrect member	☐ **Provider:** Processed under incorrect provider/tax ID number
Coordination of Benefits Information: ☐ Alternate Insurance Information/EOP Attached ☐ COB – Related Adjustment Primary Insurance	☐ **Timely Filing:** Attach claims and supporting documentation showing claim was filed to BCBSIL in a timely manner
PLEASE NOTE: This form is for claim payment disputes related to reimbursement rate or processing. This form is **NOT intended for requests related to clinical reviews** for medical necessity determinations in the case of a denied authorization or retrospective review request. To request a Service Authorization Dispute (medical necessity) please use this form.	☐ **Payment Amount:** _____ ☐ **Claims Reversal Needed** Reason: _____ ☐ **Under/Overpayment –** Explain the reasoning: _____ ☐ **Service is not a duplicate –** Explain the reasoning: _____ ☐ **Prior-authorization now on file –** #_____
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.