



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 please refer to the provider manual for Blue Cross Community MMAI (Medicare-Medicaid Plan)SM.

Please return this completed form and any supporting documentation to:

By mail: Blue Cross Community MMAI
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.

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 MMAI** ☐ Non-contracted provider
☐ Contracted provider
- 6) **Total number of faxed pages attached to this form (including cover sheet)** _____

SECTION 1: CLAIM STATUS INQUIRY

Fax #: 855-756-8727

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 reasons and attach all supporting documentation

<input type="checkbox"/> Member: Processed under incorrect member	<input type="checkbox"/> Provider: Processed under incorrect provider/tax ID number
Coordination of Benefits Information: <input type="checkbox"/> Alternate Insurance Information/EOP Attached <input type="checkbox"/> COB – Related Adjustment Primary Insurance	<input type="checkbox"/> 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) use this form .	<input type="checkbox"/> Payment Amount: _____
	<input type="checkbox"/> Claims Reversal Needed Reason: _____
	<input type="checkbox"/> Under/Overpayment – Explain the reasoning: _____
	<input type="checkbox"/> Service is not a duplicate – Explain the reasoning: _____
	<input type="checkbox"/> 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.