Kansas City

Claim Inquiry

Please attach a copy of the claim or remittance advice. Inquiries are accepted 30 or more days from the original submission date, but will not be accepted after 180 days passes.

To comply with Missouri Prompt Pay Statutes 376.383 and 376.384, indicate if you are responding to a request for additional information from Blue KC. ◉ **Yes** ○ **No**

Provider Name _____ **Telephone** _____

Practitioner Number _____ **Fax to Attn** _____

Group / Facility Number _____ **Provider Fax Number** _____

Group Name (if applicable) _____ **Date of Service** _____

Patient Name _____ **Total Charges** _____

ID Number _____ **Original Claim Number** _____
(including Alpha Prefix)

Policyholder's Name _____

☐ **Corrected Claim (attached)** ☐ **Overpayment**

☐ **Questioning Allowable** *(When selected, add Member Plan Name, Billing Code, and Expected Reimbursement below. Otherwise, skip these fields.)*

Member Plan Name _____

Attach copy of applicable fee schedule for an expedited response.

Billing Code	**Expected Reimbursement**
_____	**$**_____
_____	**$**_____
_____	**$**_____

☐ **Other** (please explain):

Completed by: _____ **Date:** _____

All supporting documentation must clearly identify the patient's name, policyholder's ID #, and date of service.

Reserved for Blue KC response

_____ **Respondent's Name**

_____ **Inquiry / Worksheet Number**

_____ **Date**

Please fax this form to:

Local HMO / PPO: 816-395-3959 **Blue Card:** 816-278-1924 **FEP:** 816-395-3811

White Copy - Blue Cross and Blue Shield of Kansas City Yellow Copy - Provider 40-20-15