BlueCross BlueShield of Kansas City

Claim Inquiry

Please attach copy of claim or remittance advice

Please wait at least 30 days, but no more than 180 days, from the original submission date before you send an inquiry on claim status.

In order for Blue KC to comply with Missouri Prompt Pay Statutes 376.383 and 376.384 please indicate if you are responding to a request for additional information from Blue KC.

Yes ☐ **No** ☐

PROVIDER

Provider Name _____ **Telephone** (____)_____

Practitioner N umber _____ **Fax to Attn** _____
(8 digit – REQUIRED) (your name)

Group or Facility Number (if applicable) _____ **Provider Fax Number** _____
REQUIRED

Group Name (if applicable) _____

Patient Name _____ **Date of Service** _____
Last First Middle

ID Number Including Alpha Prefix_____ **Total Charges** _____
REQUIRED

Policy Holder's Name _____ **Original Claim Number** _____
Last First Middle

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

☐ **Questioning Allowable** (please submit Operative/Emergency Room report, Certificate of Medical Necessity, and/or vendor invoice showing the charges billed)

☐ **Other**: (Explain question fully): _____

_____

_____

_____

_____

_____

_____

Completed by: **Date**:

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

This area reserved for Blue Cross and Blue Shield of Kansas City response.

_____ _____ _____
Respondent's Name **Inquiry / Worksheet Number** **Date**

TO ELIMINATE MAIL TIME PLEASE FAX THIS FORM TO:

Local HMO/PPO 816-395-3959**, BlueCard** 816-817-3381**, FEP** 816-395-3811

OR MAIL HARD COPY TO:

For local business: Blue Cross and Blue Shield of Kansas City, Attn: Correspondence, PO Box 419169, KC, MO 64141-6169.

For BlueCard: Blue Cross Blue Shield of Kansas City, Attn: Correspondence, PO Box 419016, KC, MO 64141-6016

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