PROVIDER INQUIRY

(PLEASE PRINT)

Mountain State BlueCross BlueShield

MAIL INQUIRY TO:

MOUNTAIN STATE BLUE CROSS & BLUE SHIELD
P.O. BOX 7026
WHEELING, WV 26003

ATTN: CUSTOMER SERVICE

PROVIDER NAME ______________________________

ADDRESS ______________________________

CITY ______________ **STATE** ______ **ZIP** ______

FEDERAL TAX ID ______________ **SUFFIX** ______ **TELEPHONE** ______________

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PAR NON-PAR

FEDERAL TAX ID ______________ SUFFIX ______ PAR ☐ NON-PAR ☐ TELEPHONE ( ) ______________

(ALL COPIES OF INQIRY MUST BE LEGIBLE.)

SUBSCRIBER ID #: ______________________ DATE OF SERVICE: ______________________

SUBSCRIBER NAME: ______________________ BCBS CLAIM #: ______________________

PATIENT NAME: ______________________ RELATIONSHIP TO INSURED: ______________________

TYPE OF SERVICE: ______________________ TOTAL CHARGES: ______________________

______________________ **PLACE OF SERVICE:**

______________________ OUTPATIENT (ER) ______ OUTPATIENT (DIAG) ______

DATE SUBMITTED TO MSBCBS: ______________________ INPATIENT ______ OFFICE ______ OTHER ______

REASON FOR INQUIRY: ____

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____

CONTACT PERSON: ____

RESPONSE: ____

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______________________ ______________________
REPRESENTATIVE DATE COMPLETED

(FOR OFFICE USE ONLY)

RECEIVED

BY: ______________ DATE: ________ TIME: ________

SOURCE: P H S A TYPE: W P L

NMIS: TYPE I DAYS ______________

COMPLETED

BY: ______________ DATE: ________ TIME: ________

TYPE: I C L ADJ. DAYS: ________

TYPE II DAYS ______________

CALL BACK DATE	TIME	REF. TO DEPT.	DATE IN	DATE OUT

PR043 (REV. F: 7-05)