

**ELECTRONIC CLAIM ATTACHMENT
COVER SHEET**

Date: _____ **Number of Pages (including cover sheet)** _____

Attention: CDC AREA

Fax number: (304) 234-7086

MAILING ADDRESS: MSBCBS, P.O. BOX 7026, WHEELING, WV 26003-0766

From (Provider Name): _____

Fax number: _____ **Phone Number:** _____

Office Contact (Sender) Name: _____

Please check one of the following:

This is a first time submitted electronic claim with the PWK indicator reported on the claim. Patient account number _____

This information is for a claim already received by Mountain State Blue Cross Blue Shield. Mountain State claim number _____

Patient Name: _____

Subscriber ID Number: _____

Service Date: _____ **Total Charges:** _____

Provider Legacy and/or NPI Number: _____

Attachment Control Number: _____

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