



PROVIDER INQUIRY FORM

If you are an electronic biller, please submit this request electronically through the Claim Investigation Inquiry in Availity or as an 837 adjustment request.

This form should only be used for requests on previously processed claims. New claims should be submitted directly to the plan electronically or by mail if you are not currently an electronic biller

Mail all inquiries to:
 Highmark Blue Cross Blue Shield
 of Western New York
 PO Box 4208
 Buffalo, NY 14240-4208

Provider Name:	Member Name:
Provider Street Address, City, State, ZIP:	Member ID Number (Including Prefix):
Provider NPI:	Member Group Number:
Provider Tax ID:	Claim Number:
Date of Service:	

Please select the appropriate adjustment request reason, provide detailed information, and attach any supporting documentation.

Have you utilized your online resources? Availity, Claim Investigation Inquiry, Claim Status Inquiry

<input type="checkbox"/>	BlueCard® Reconsideration/Appeal for an Out-of-Area Member: **Only use for NON-Highmark BCBSWNY members <input type="checkbox"/> Claim denied, not medically necessary <input type="checkbox"/> Claim denied, experimental/investigational <input type="checkbox"/> Claim denied, cosmetic in nature
<input type="checkbox"/>	Correction/Adjustment Being Made to Original Claim: <input type="checkbox"/> Procedure code <input type="checkbox"/> Modifier <input type="checkbox"/> Diagnosis code <input type="checkbox"/> Number of units <input type="checkbox"/> Itemized bill attached <input type="checkbox"/> Other:
<input type="checkbox"/>	Member Eligibility Issue: <input type="checkbox"/> Denied no coverage <input type="checkbox"/> Newborn added to policy <input type="checkbox"/> Wrong member billed <input type="checkbox"/> Other:
<input type="checkbox"/>	Payment Withdrawal Request: Retraction Amount: _____ <input type="checkbox"/> Duplicate payment <input type="checkbox"/> Services not rendered <input type="checkbox"/> Wrong carrier billed <input type="checkbox"/> Paid to wrong provider
<input type="checkbox"/>	Original Claim Denied for Timely Filing (Proof of Timely Filing Attached): *only use this form if claim is beyond timely filing period <input type="checkbox"/> Submitted to wrong carrier <input type="checkbox"/> Original carrier retracted payment <input type="checkbox"/> Issue with electronic submission
<input type="checkbox"/>	Original Claim Denied for Authorization. Valid Authorization Number on File: _____
<input type="checkbox"/>	Incorrect Payment Was Received for the Service: <input type="checkbox"/> Wrong allowance paid <input type="checkbox"/> Payment not consistent with units billed <input type="checkbox"/> Claim processed as OON in error
<input type="checkbox"/>	Issue with Member Benefits: <input type="checkbox"/> Benefit quoted was not received <input type="checkbox"/> Services denied non-covered <input type="checkbox"/> Wrong copay/coinsurance applied
<input type="checkbox"/>	Additional Information Was Requested on Remittance: <input type="checkbox"/> Medical records <input type="checkbox"/> Operative reports <input type="checkbox"/> Primary EOB attached <input type="checkbox"/> Medicare primary (EOMB attached)
<input type="checkbox"/>	Additional Comments:

-Over-

Date Submitted:	Provider Office Contact Name:
	Provider Office Phone Number: