BlueCross BlueShield of Texas

# Claim Review Form

## CLAIM DATA *(All fields are required)*

| | | | |
|---|---|---|---|
| Today's Date: | | Group Number: *(From your Provider Claim Summary)* | |
| Member's Identification Number: *(Include 3 character alpha prefix)* | | | |
| Member's Name: *(Last Name, First Name)* | | | |
| Patient's Name: *(Last Name, First Name)* | | | |
| Date(s) of Service and Billed Amount: | | | |
| DCN (Claim Number Assigned by BCBS) *(Do not resubmit the claim unless there are corrections.)* | | | |

- This form must be placed on top of the correspondence you are submitting.
- Do not attach claim forms unless it is a corrected claim from the original claim listed above.
- Please include supporting documentation to facilitate your review.

## TYPE OF REVIEW

You must check one of the following:

- ☐ Additional Information requested by BCBS (example COB, Medicare EOMB)
- ☐ Claim Review
- ☐ Medical Records
- ☐ ClaimCheck®/ClaimsXten™

Please include detailed information as to the nature of your review. If a corrected claim has been attached, please specify the corrections that were made.

| | | | | | |
|---|---|---|---|---|---|
| Provider Name: | | | | | |
| NPI Number: | | | | | |
| Billing Address: | | City: | State: | Zip: | |
| Email Address: | | Fax Number: | | | |
| Contact Person: | | Phone Number: | | | |

## INSTRUCTIONS FOR COMPLETING THE CLAIM REVIEW FORM *(Submit only one patient per form)*

***This form is not necessary if you have received a letter requesting information. Please submit the requested information using the letter of request as a cover sheet. This letter will contain a barcode in the upper right corner of the page.

***If you are submitting a Predetermination please utilize the "Predetermination Request Form" located on our website.

Use this form to request a review of previously adjudicated claims. The common reasons for review are listed below (this is not an all inclusive list):

- Allowed Amount or Contractual Amount
- Corrected claims
- Coordination of Benefits
- Diagnosis Codes
- Explanation of Benefits from other carriers
- Itemized Bills (speech, occupational and physical therapies)
- Proof of Medicare Exhaust
- Place of treatment changes
- Procedure/revenue code
- Refund Dispute (Recoupment)
- Other

Include all required information, such as claim and provider data, the reason for the review and any necessary documentation.

**Please Note:** Inquiries received without the member's group and ID number cannot be completed, and may be returned to you to supply this information.

**Original claims should not be attached** to the Claim Review Form. If attached, they will be returned back to you with a letter explaining the correct procedures for submitting claims.

**Please mail the inquiries to:**
Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, TX 75266-0044