BlueCross BlueShield of Texas

Additional Information Form

Additional Information requested may be submitted with the letter received or this form.
DO NOT USE THIS FORM UNLESS YOU HAVE RECEIVED A REQUEST FOR INFORMATION.
Original Claims should not be submitted with this form.
Submit only one form per patient.

*****Inquiries received without the required information below may not be reviewed.*****

Claim Number:	**(For multiple claims provide additional claim number below)**	
Group Number:	Prefix (3 character alpha):	Member Identification Number:
Patient Name: (Last, First)		
Date(s) of Service:	Total Billed Amount:	
Provider Name:	NPI:	
Contact Person:	Phone Number:	
Additional Information requested:		

REMINDERS

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

- **Claim Review requests** – If you did not receive a letter requesting additional information but are requesting a review of a previously adjudicated claim, use the Claim Review Form located at bcbstx.com/provider.
- **Corrected Claim requests** should be submitted as electronic replacement claims, or on a paper claim form along with a Corrected Claim Review Form available on our website at bcbstx.com/provider.

To view Claim Status online utilize the Claim Research Tool (CRT) on the Availity™ Web Portal at *availity.com*.