

Claim Correspondence – Submission Form

This form should be completed by providers for claim correspondence only.

MEMBER INFORMATION:

Member First/Last Name _____	Member Date of Birth _____
Member Coverage: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	
Member ID: _____	

PROVIDER/PROVIDER REP INFORMATION:

Provider First/Last Name _____	
Provider Street Address _____	
City _____	State _____ ZIP _____ Phone (____) _____
National Provider Identification (NPI) # _____	
<input type="checkbox"/> I am a participating provider	<input type="checkbox"/> I am a nonparticipating provider
Provider Representative: <input type="checkbox"/> Self <input type="checkbox"/> Billing Agency <input type="checkbox"/> Law Firm <input type="checkbox"/> Other: _____	
Representative Contact Name: _____ Contact Phone (____) _____	
Rep Street Address _____	
City _____	State _____ ZIP _____

CLAIM INFORMATION*:

Claim # _____	Billed Amount \$ _____	Amount Received \$ _____
Start Date of Service _____	End Date of Service _____	Authorization Number _____

* If you have multiple claims related to the **same** issue, you can use one form and attach a listing of the claims with each supporting document following behind.

CLAIM CORRESPONDENCE

Claim correspondence is defined as a request for additional/needed information in order for a claim to be considered clean, to be processed correctly or for a payment determination to be made.

To ensure timely and accurate processing of your request, please complete the section below by checking the applicable category your correspondence applies to.

- | | | |
|--|---|--|
| <input type="checkbox"/> Itemized Bill | <input type="checkbox"/> Sterilization Consent Form | <input type="checkbox"/> Hysterectomy Consent Form |
| <input type="checkbox"/> Abortion Consent Form | <input type="checkbox"/> Invoice | <input type="checkbox"/> Medical Records |
| <input type="checkbox"/> Corrected Claim | <input type="checkbox"/> Other Health Insurance Information | <input type="checkbox"/> Other: _____ |

Mail this form, a listing of claims (if applicable) and supporting documentation to:

**Claim Correspondence
Anthem Health Plans of Kentucky
PO Box 61599
Virginia Beach, Virginia 23466**