



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	Member ID: _____	

Provider/Provider Representative Information:

Provider First/Last Name: _____			
Provider Street Address: _____			
City: _____	State: _____	ZIP Code: _____	Phone (_____) _____
National Provider Identification Number: _____			
Select one: <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 (_____) _____	
Representative Street Address: _____			
City: _____	State: _____	ZIP Code: _____	

Claim Information*:

Claim Number: _____	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: _____ |
| <input type="checkbox"/> ER Level of Payment Review | | |

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

Anthem HealthKeepers Plus
Claim Correspondence
P.O. Box 27401
Richmond, VA 23279-7401