Anthem BlueCross BlueShield

BadgerCare Plus

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: ☐ Medicaid ☐ Medicare

Member ID: _____

PROVIDER/PROVIDER REP INFORMATION:

Provider First/Last Name_____ _____

Provider Street Address_____

City_____ State_____ Zip_____ Phone (_____)

_____

National Provider Identification (NPI) #_____

☐ I am a participating provider ☐ I am a nonparticipating provider

Provider Representative: ☐ Self ☐ Billing Agency ☐ Law Firm ☐ 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.

□ Itemized Bill
□ Abortion Consent Form
□ Corrected Claim
□ Sterilization Consent From
□ Invoice
□ Other Health Insurance Information
□ Hysterectomy Consent Form
□ Medical Records
□ Other: _____

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

Claim Correspondence
Anthem Blue Cross and Blue Shield
P.O. Box 61599
Virginia Beach, VA 23466-1599