



Claim Status Request Form

Date Submitted: _____

Please complete this form when requesting claim status for a specific date(s) of service. Return the form to: ATTN: BCBST Correspondence, PO Box 180150, Chattanooga, TN 37401. If you have any questions, please call 1-800-924-7141.

Subscriber ID Number: _____

Member/Patient Name: _____

Member/Patient's Date of Birth: _____

BCBST Provider ID number: _____

Individual Provider Name: _____

Date(s) of Service: _____ Total billed charge: _____

Any additional comments:

BCBST Response: _____ Date: _____

_____ We show no record of receiving the claim(s) in question, please resubmit.

_____ The claim was:

_____ Paid on ___/___/___ to: _____ in the amount of \$ _____
_____ Claim #: _____ Patient liability: \$ _____
_____ Allowed amount: \$ _____ Copay: \$ _____
_____ Deductible: \$ _____ Coinsurance: \$ _____

_____ Denied on ___/___/___ due to: _____
Claim #: _____

_____ Received on ___/___/___ and currently being reviewed. The claim should complete processing within 7-14 business days. Claim #: _____

Any additional comments:

If you have any questions, please contact our Provider Service Department at 1-800-924-7141, 8:00 a.m. to 5:15 p.m. ET Monday through Friday.

Sincerely,

Provider Service Center