



# 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