**Fax: 1-423-535-5498 Email:** **BlueAdvantageCS\_GM@BCBST.com**

# Please complete all shaded areas for HIPAA verification

 **Status Checks**

|  |
| --- |
| **Provider Fax Number:**  |
|  | **Provider Number/Tax ID** | **Member Name** | **Member ID Number** | **Date of Service** | **Total Amount****Billed** | **Remittance Advice Date** | **Paid Amount** | **Claim #/Status** |
| **1** |  |  |  |  |  |  |  |  |
| **2** |  |  |  |  |  |  |  |  |
| **3** |  |  |  |  |  |  |  |  |
| **4** |  |  |  |  |  |  |  |  |
| **5** |  |  |  |  |  |  |  |  |
| **6** |  |  |  |  |  |  |  |  |
| **7** |  |  |  |  |  |  |  |  |
| **8** |  |  |  |  |  |  |  |  |
| **9** |  |  |  |  |  |  |  |  |
| **10** |  |  |  |  |  |  |  |  |

**Disclaimer**: These benefits are based on the information you have given us today. Due to possible contract changes or policy cancellation, final determination will be made when claims are received. This information is subject to change based on eligibility. .

# Signature: Date:

Please allow 7 business days for response.