



BlueCross BlueShield
of Kansas City

Claim Inquiry

Please attach copy of claim or
remittance advice

Please wait at least 30 days, but no more than 180 days, from the original submission date before you send an inquiry on claim status.

In order for Blue KC to comply with Missouri Prompt Pay Statutes 376.383 and 376.384 please indicate if you are responding to a request for additional information from Blue KC.

Yes

No

P R O V I D E R	Provider Name _____	Telephone (____) _____
	Practitioner Number _____ (8 digit – REQUIRED)	Fax to Attn _____ (your name)
	Group or Facility Number (if applicable) _____	Provider Fax Number _____ REQUIRED
	Group Name (if applicable) _____	
	Patient Name _____ Last First Middle	Date of Service _____
	ID Number Including Alpha Prefix _____ REQUIRED	Total Charges _____
	Policy Holder's Name _____ Last First Middle	Original Claim Number _____
	<input type="checkbox"/> Corrected Claim (attached) <input type="checkbox"/> Overpayment	
	<input type="checkbox"/> Questioning Allowable (please submit Operative/Emergency Room report, Certificate of Medical Necessity, and/or vendor invoice showing the charges billed)	
	<input type="checkbox"/> Other: (Explain question fully): _____ _____ _____ _____ _____	
Completed by: _____	Date: _____	

All supporting documentation must clearly identify the patient's name, policy holder's ID # and date of service.

This area reserved for Blue Cross and Blue Shield of Kansas City response.

Respondent's Name _____

Inquiry / Worksheet Number _____

Date _____

TO ELIMINATE MAIL TIME PLEASE FAX THIS FORM TO:

Local HMO/PPO 816-395-3959, BlueCard 816-278-1924, FEP 816-395-3811

OR MAIL HARD COPY TO:

For local business: Blue Cross and Blue Shield of Kansas City, Attn: Correspondence, PO Box 419169, KC, MO 64141-6169.

For BlueCard: Blue Cross Blue Shield of Kansas City, Attn: Correspondence, PO Box 419016, KC, MO 64141-6016