BlueCross BlueShield of Texas

Additional Information Form

Additional Information requested may be submitted with the letter received or this form.
DO NOT USE THIS FORM UNLESS YOU HAVE RECEIVED A REQUEST FOR INFORMATION.
Original Claims should not be submitted with this form.
Submit only one form per patient.

*****Inquiries received without the required information below may not be reviewed.*****

Claim Number:		***(For multiple claims, provide the additional claim number below)***
Group Number:	Prefix *(3 character alpha)*:	Member Identification Number:
Patient Name: *(Last, First)*		
Date(s) of Service:	Total Billed Amount:	
Provider Name:	NPI:	
Contact Person:	Phone Number:	
Additional Information requested:		

REMINDERS

- **Mail inquiries to:** Blue Cross and Blue Shield of Texas
  P.O. Box 660044
  Dallas, TX 75266-0044
- **Claim Review requests:** If you did not receive a letter requesting additional information but are requesting a review of a previously adjudicated claim, use the Claim Review Form on the Forms page of our Provider website, bcbstx.com/provider.
- **Corrected Claim requests** should be submitted as electronic replacement claims, or on a paper claim form along with a Corrected Claim Form. This form is online at bcbstxcom/provider.

To view claim status online, use the Claim Status Tool on Availity® Essentials at availity.com.