

PROVIDER INQUIRY RESOLUTION FORM

This form should be used when submitting an inquiry. Instructions:

- Use a separate form for each patient in question.
- Include the entire subscriber identification number, including the prefix.
- Attach a copy of the claim with any additional information that might assist in the review process.
- Please allow 30 days for a response.
- See reverse side for mailing information.

Date: _____

Provider/Practice Name & Address:	Provider/Rendering Number:	NPI:
Prefix and Subscriber ID:	Claim Number:	
Patient First Name:	Patient Last Name:	
From Date of Service:	To Date of Service:	
Patient Account #:	Total Claim Charge:	
Primary Reason for Inquiry (Please check one):		Provider Type:
<input type="checkbox"/> Authorizations <input type="checkbox"/> Medical Records <input type="checkbox"/> Review Amount Paid <input type="checkbox"/> Correct Frequency <input type="checkbox"/> Procedure/Code <input type="checkbox"/> Review Rejections <input type="checkbox"/> ICD-9 <input type="checkbox"/> Referral <input type="checkbox"/> Timely Filing <input type="checkbox"/> Rejection Code _____ <input type="checkbox"/> Other: _____		<input type="checkbox"/> Ancillary <input type="checkbox"/> Institutional <input type="checkbox"/> Dental <input type="checkbox"/> Professional <input type="checkbox"/> Other: _____
Reason for Review (Please be specific):		
Office Contact Person:	Telephone:	E-mail Address (optional):

continued...

FOR PROVIDER USE ONLY

To facilitate a quicker response to your inquiry, please complete this form and attach all relevant claim information (claim, EOMB, operative notes) and send to the proper address below based on the member's insurance coverage:

■ **MD, NCA, BlueChoice, local BlueCard and NASCO Correspondence:**

(Providers submitting non-FEP inquiries)

Mail Administrator

P.O. Box 14114

Lexington, KY 40512-4114

■ **FEP- Federal Employee Program:**

(Providers in Montgomery & Prince Georges counties, Washington, DC and Northern Virginia)

Mail Administrator

P.O. Box 14112

Lexington, KY 40512-4112

■ **All Other MD FEP Inquiries:**

Mail Administrator

P.O. Box 14111

Lexington, KY 40512-4111

Copies of this form may be obtained by visiting www.carefirst.com › *Providers & Physicians* › *Forms*.
