



## 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.\*\*\***

<b>Claim Number:</b>			<i>(For multiple claims provide additional claim number below)</i>
Group Number:	Prefix (3 character alpha):	Member Identification Number:	
Patient Name: <i>(Last, First)</i>			
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 Illinois  
P.O. Box 805107  
Chicago, IL 60680-4112
- **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 located at [bcbsil.com/provider](http://bcbsil.com/provider).
- **Corrected Claim requests** should be submitted as electronic replacement claims, or on a paper claim form along with a Corrected Claim Review Form available on our website at [bcbsil.com/provider](http://bcbsil.com/provider).

**To view Claim Status online utilize the Claim Status Tool on the Availity® Provider Portal at [availity.com](http://availity.com).**