HIGHMARK
WESTERN NEW YORK

PROVIDER INQUIRY FORM

If you are an electronic biller, please submit this request electronically through the Claim Investigation Inquiry in Availity or as an 837 adjustment request.

This form should only be used for requests on previously processed claims. New claims should be submitted directly to the plan electronically or by mail if you are not currently an electronic biller

Mail all inquiries to:
Highmark Blue Cross Blue Shield
of Western New York
PO Box 4208
Buffalo, NY 14240-4208

Provider Name:	**Member Name:**
Provider Street Address, City, State, ZIP:	**Member ID Number (Including Prefix):**
Provider NPI:	**Member Group Number:**
Provider Tax ID:	**Claim Number:**
Date of Service:	

Please select the appropriate adjustment request reason, provide detailed information, and attach any supporting documentation.

Have you utilized your online resources? Availity, Claim Investigation Inquiry, Claim Status Inquiry

☐ **BlueCard® Reconsideration/Appeal for an Out-of-Area Member:** ****Only use for NON-Highmark BCBSWNY members**
☐ Claim denied, not medically necessary ☐ Claim denied, experimental/investigational
☐ Claim denied, cosmetic in nature

☐ **Correction/Adjustment Being Made to Original Claim:**
☐ Procedure code ☐ Modifier ☐ Diagnosis code ☐ Number of units ☐ Itemized bill attached
☐ Other:

☐ **Member Eligibility Issue:**
☐ Denied no coverage ☐ Newborn added to policy ☐ Wrong member billed ☐ Other:

☐ **Payment Withdrawal Request:** **Retraction Amount:** _____
☐ Duplicate payment ☐ Services not rendered ☐ Wrong carrier billed ☐ Paid to wrong provider

☐ **Original Claim Denied for Timely Filing (Proof of Timely Filing Attached):**
***only use this form if claim is beyond timely filing period**
☐ Submitted to wrong carrier ☐ Original carrier retracted payment ☐ Issue with electronic submission

☐ **Original Claim Denied for Authorization.**
Valid Authorization Number on File: _____

☐ **Incorrect Payment Was Received for the Service:**
☐ Wrong allowance paid ☐ Payment not consistent with units billed ☐ Claim processed as OON in error

☐ **Issue with Member Benefits:**
☐ Benefit quoted was not received ☐ Services denied non-covered ☐ Wrong copay/coinsurance applied

☐ **Additional Information Was Requested on Remittance:**
☐ Medical records ☐ Operative reports ☐ Primary EOB attached ☐ Medicare primary (EOMB attached)

☐ **Additional Comments:**

-Over-

Date Submitted:	**Provider Office Contact Name:**
	Provider Office Phone Number: