



PROVIDER CLAIM INQUIRY FORM

Inquiry type: Amount of payment questioned Denied claim questioned

To ensure that your request is handled promptly and accurately, please mail the completed form and supporting documentation to the address listed in the box below. If you do not include the claim number, then you *must* include the Statement of Remittance (SOR).

**IBC Provider Claim Inquiries
P.O. Box 7930
Philadelphia, PA 19101-7930**

Note: If your office is registered with NaviNet[®], please submit claim inquiries electronically.

Member's plan: Personal Choice[®] Personal Choice 65SM PPO Keystone POS/Direct POS
 Keystone Health Plan East HMO Keystone 65 HMO Other _____

Practice name			Provider number/NPI	
Street address			Name of contact person	
City	State	ZIP	Telephone number	
Member name			Patient's name	
Member ID			Check number	
Claim number			Date of check or explanation	
Date of service			Place of service	

Detailed inquiry reason

Independence Blue Cross maintains processes to address and resolve provider inquiries and provider complaints related to the adjustment of claims. If you would like us to investigate the way we have processed a particular claim, please complete this form and send it to us, along with the SOR (or claim number) and any supporting documentation to the address above.

We will investigate your claims-related issue, process any required adjustments, or send you a written resolution letter regarding the processing of the claim.

If you have any questions, please contact Customer Service at 1-800-ASK-BLUE.

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