PROVIDER INQUIRY
(Please Print)

____
Provider Name

____
Address

____
City State Zip

____
NPI # / Federal Tax ID #

For correct routing, please check the appropriate box.

Highmark West Virginia Providers mail to:

☐ Highmark Blue Cross Blue Shield WV
P O Box 7026
Wheeling WV 26003

Medicare Advantage PPO Providers mail to:

☐ Highmark Blue Cross Blue Shield WV
P O Box 7004
Wheeling WV 26003

____
Telephone #

Member ID #______________________________

Date of Service ______________________________

Policy Holder ______________________________

Claim # ______________________________

Patient Name ______________________________

Relationship To Policy Holder ______________

Type Of Service ______________________________

____

____

Total Charges ______________________________

Place Of Service :

Outpatient (ER)___ Outpatient (Diag) ___

Inpatient ___ Office ___ Other ___

Date Submitted to MSBCBS ________________

Reason For Inquiry ______________________________

____

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Contact Person ______________________________

Revised 04/28/11