



**BlueCross BlueShield
of Florida**

An Independent Licensee of the
Blue Cross and Blue Shield Association

**Mail to: Blue Cross and Blue Shield of Florida
P. O. Box 1798
Jacksonville, FL 32231-0014**

Provider Claim Inquiry Form

Send only one form per claim.

Date _____

1. Provider Information

Name	BCBSF Number	National Provider Identifier (NPI)		
Street Address	City	State	Zip	
Telephone Number ()	Fax Number ()			
Contact Name				

2. Member Information

Last Name	First Name
Member/Contract Number (alphas and numerics)	Date of Birth

3. Claim Information

Claim Number	Authorization Number, if applicable
Billed Amount	Date(s) of Service (From) (To)

4. Reason for Inquiry

- Corrected Claim/Late Charges (explain all changes in the space below)
- Medical Records Attached
- Other (explain the reason in the space below)
