



PROVIDER INQUIRY FORM
BlueLink TPA

One form per inquiry

Today's Date: _____ Provider ID#: _____ Provider Name: _____

Your Name: _____ Phone #: _____ Fax #: _____

Return Address: _____

Patient Account Number: _____ NPI (National Provider Identifier) Number: _____

Member ID#:	Patient Name:	Claim #:
Group #:	Billed Charge:	Service Dates (all):

INQUIRY (Status check or claim adjustment)

Fax all inquiries to (651) 662- 2745

Status Check: *Please wait 30 days from the date you submitted the claim before checking on the status of the processing.*

Claim Adjustment Request (please complete appropriate information)

- Change individual provider # to _____
- ID# should be: _____
- Service was referred, case #: _____
- Patient should be: _____
- Services should not have been billed because _____
- Overpayment / Underpayment:
- Other carrier paid (include EOB)
 - Medicare paid (include EOB)
 - Worker's Compensation paid
- Change diagnosis _____ to _____
- Add modifier ____ to procedure code _____
- Change procedure _____ to _____
- Not our patient, please recoup claim.
- No fault auto paid
- Other: _____

APPEAL

Use the Administrative Uniformity Committee (AUC) form to request a reconsideration of a previously adjudicated claim for which there is no additional or corrected data to be submitted, visit their website at:
<http://www.health.state.mn.us/auc/index.html>

Fax the AUC form to (651) 662- 2745

An appeal is a denial, reduction, termination of, or a failure to provide or make payment (in whole or part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment.

Indicate here if multiple related inquiries are being submitted for the same member.
Specify number in ____ of ____ format (e.g. 1 of 5, or 3 of 10).