



Additional Information Form

Additional Information requested may be submitted with the letter received or this form.
DO NOT USE THIS FORM UNLESS YOU HAVE RECEIVED A REQUEST FOR INFORMATION.
Original Claims should not be submitted with this form.
Submit only one form per patient.

Inquiries received without the required information below may not be reviewed.

Claim Number: (For multiple claims provide additional claim number below)		
Group Number:	Prefix (3 character alpha):	Member Identification Number:
Patient Name: (Last, First)		
Date(s) of Service:	Total Billed Amount:	
Provider Name:	NPI:	
Contact Person:	Phone Number:	
Additional Information requested:		

REMINDERS

Mail inquiries to: Blue Cross and Blue Shield of New Mexico
P.O. Box 27630
Albuquerque, NM 87125-7630

- Claim Review requests** – If you did not receive a letter requesting additional information but are requesting a review of a previously adjudicated claim, use the Claim Review Form located at bcbsnm.com/provider.
- Corrected Claim requests** should be submitted as electronic replacement claims, or on a paper claim form along with a Corrected Claim Review Form available on our website at bcbsnm.com/provider.

To view Claim Status online utilize the Claim Research Tool (CRT) on the Availity™ Web Portal at availity.com.

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