BlueCross BlueShield of Oklahoma

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 Oklahoma
P.O. Box 3283
Tulsa, OK 74102-3283

- **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 bcbsok.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 bcbsok.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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