

# Claim Follow Up Form

Medicaid

## Provider Information

_____ Sent by	_____ Date Sent
_____ Hospital/Facility/Physician	_____ Phone Number
_____ NPI Number	_____ Provider Tax ID Number

## Member Information

_____ Patient Name	_____ Date of Service
_____ Original Claim Number	_____ Original Date of Claim
_____ Member ID Number	_____ Medicaid ID Number

**INSTRUCTIONS: Please remember you have 90 days from the date of our request/denial to submit a corrected claim.** Please attach the proper documentation, including a copy of any applicable correspondence received from BlueChoice HealthPlan Medicaid.

After completing this form, place it on top of all documentation and mail to:

**Attn: Claims  
BlueChoice HealthPlan of South Carolina  
P.O. Box 100148  
Columbia, SC 29202-3148**

**A copy of the claim should not be submitted with the documentation requested, unless otherwise denoted by an asterisk (\*).**

For follow-up of a returned claim, check all that apply:

- COB/Medicaid Information
- Corrected Billing\*
- EOMB/EOB of Primary Insurance Carrier
- Hard Copy of Itemized Bill for a Previously Submitted Claim
- Medical Records
- Patient Eligibility Verified (through Customer Service, IVR, Provider Access)
- Other: \_\_\_\_\_

To request a claim adjustment, check all that apply:

- Additional Charges\*
- Other Action Required: \_\_\_\_\_

**HMO Use Only: (consult your HMO Agreement if you are uncertain which choice applies)**

- Eligibility Guarantee Claims
- Enrollment Protection Claims
- Non Cap Discrepancies
- Other: \_\_\_\_\_