Provider Inquiry Resolution Form

CareFirst Family of health care plans

INSTRUCTIONS

Important: Do not use this form for Appeals or corrected claims. This form is to be used for Inquiries only.

For more information on submitting Inquiries and Appeals, please visit **carefirst.com/inquiriesandappeals**.

Helpful Tips:

- Use a separate form for each patient
- Include the entire subscriber identification number, including the prefix
- Attach a copy of the claim with any additional information that might assist in the review process
- Please allow 30 days for a response

FOR PROVIDER USE ONLY

To help expedite your Inquiry, please complete this form and attach all relevant claim information (claim, EOB, operative notes, etc.) and send to the address below that corresponds to the member's insurance coverage.

- MD, NCA, BlueChoice, local BlueCard and NASCO Correspondence
  (Providers submitting non-FEP inquiries)
  Mail Administrator
  P.O. Box 14114
  Lexington, KY 40512-4114
- FEP—Federal Employee Program
  (Providers in Montgomery & Prince Georges counties, Washington, DC and Northern Virginia)
  Mail Administrator
  P.O. Box 14112
  Lexington, KY 40512-4112
- All Other MD FEP Inquiries
  Mail Administrator
  P.O. Box 14111
  Lexington, KY 40512-4111

Visit **carefirst.com/providerforms** to download a copy of this form.

INFORMATION

Date		
Provider/Practice Name & Address	Provider/Rendering #	NPI
	Email Address for Accounts Receivable	
Prefix and Subscriber ID	Claim #	
Patient First Name	Patient Last Name	
From Date of Service	To Date of Service	
Patient Account #	Total Claim Charge	
Reason for Your Inquiry		
Provider Type ◯ Ancillary ◯ Dental ◯ Institutional ◯ Professional ◯ Other _____		
Contact Person	Contact Telephone #	Contact Email Address

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