Healthy Blue

Medicaid Managed Care

Claim Correspondence — Submission Form

This form should be completed by providers for claim correspondence only.

Member information

Member first/last name:	Member DOB:
Member coverage: ☐Medicaid	Member ID:

Provider/provider representative information

Provider first/last name:				
Provider street address:				
City:	State:	ZIP code:	Phone:	
National provider identification number:				
Select one:	☐ I am a participating provider.	☐ I am a nonparticipating provider.		
Provider representative:	☐ Self	☐ Billing agency	☐ Law firm	☐ Other:
Representative contact name:		Contact phone:		
Representative street address:				
City:	State:	ZIP code:		

Claim information

Claim number:	Billed amount: $	Amount received: $
Start date of service:	End date of service:	Authorization number:

* If you have multiple claims related to the same issue, you can use one form and attach a listing of the claims with each supporting document following behind.

Claim correspondence

Claim correspondence is defined as a request for additional/needed information in order for a claim to be considered clean, to be processed correctly or for a payment determination to be made.

To ensure timely and accurate processing of your request, please complete the section below bychecking the applicable category your correspondence applies to:

☐ *Abortion Consent Form*	☐ *Hysterectomy Consent Form*	☐ Medical records
☐ Corrected claim	☐ Invoice	☐ Other health insurance information
☐ ER level of payment review	☐ Itemized bill	☐ *Sterilization Consent Form*
☐ Other:		

Mail this form, a listing of claims (if applicable) and supporting documentation to:

Healthy Blue
Claims Department
P.O. Box 61010 Virginia Beach,
VA 23466-1010

https://provider.healthybluela.com

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