BLUE CROSS PPO PROVIDER
TELEPHONIC CLAIMS INQUIRY

Date: ______________

TBT Participant ID Number.
or Social Security Number:

Provider Name:

Contact
Person:

Phone Number: (   )   Fax Number (   )

☐ **Status of Claim Submitted**

1) Patient Name:

2) Date of Service:

3) Dollar Amount:

4) City where claim was mailed:

5) Date claim was mailed to TBT:

☐ Incorrect Participant

FOR TBT USE ONLY:

Claim Number:	
Date Faxed:	
Date Contacted:	
Date Entered:	
Completed By:	

Please fax to fax number
(510) 284 - 0590