



# Claim Inquiry Form

This form should only be used after calling Customer Service with no resolution.  
This inquiry is not considered an appeal.

Employee Name: \_\_\_\_\_ ID# (from card): \_\_\_\_\_

Plant Location: (City) \_\_\_\_\_ (State) \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Send BCBS Response To: (Your Home Street or P.O. Box) \_\_\_\_\_  
(City, State, Zip) \_\_\_\_\_

Your Area Code and Phone Number: (\_\_\_\_) \_\_\_\_\_

Inquiry Category (Check):  
 Outstanding Balance Bill  
 Emergency Room  
 Claim Paid as Out-of-Network  
 Coordination of Benefits (COB), BCBS is Secondary  
 Other

Details: Patient's Name \_\_\_\_\_ Date of Service \_\_\_\_/\_\_\_\_/\_\_\_\_ Amount \_\_\_\_\_

Who Provided Treatment \_\_\_\_\_ Additional Information Attached (Y/N) \_\_\_\_\_

Contacted Customer Service (date) \_\_\_\_/\_\_\_\_/\_\_\_\_ Spoke to \_\_\_\_\_

Please give a brief explanation below including the answer provided by Customer Service.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mail this form to: **Goodyear Account Management**  
**Anthem Blue Cross Blue Shield**  
**8333 Rockside Road, Suite 200**  
**Cleveland, OH 44125-6104**

Blue Cross Blue Shield Response:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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