Horizon

Inquiry Request and Adjustment Form

Please DO NOT use this form for initial claim submissions. Date of Contact _____

Provider Type

- ☐ Physician/Health Care Professional
- ☐ Institutional Provider

Request For (check one)

- ☐ Adjustment
- ☐ Corrected Claim
- ☐ Enrollment Issue
- ☐ Recapture/Overpayment
- ☐ Claim Inquiry
- ☐ Benefit Inquiry
- ☐ Other _____

Place of Service (check one only)

- ☐ Office
- ☐ Ambulatory Surgery Center
- ☐ Outpatient
- ☐ Inpatient
- ☐ Skilled Nursing Facility
- ☐ Home Health Care
- ☐ Other _____

Claim Type (check one only)

- ☐ Full Benefit/ Horizon BCBSNJ Primary
- ☐ BlueCard/ITS
- ☐ Secondary to Medicare
- ☐ COB
- ☐ Workers' Comp/No-Fault
- ☐ Other _____

Physician/Health Care Professional/Institutional Provider

Name _____ Tax ID# _____

Street Address _____ NPI # _____

City _____ Health Plan ID # _____

State _____ Office Contact Name _____

ZIP Code _____ Telephone # _____

Subscriber/Patient Information

Subscriber's Name _____ Date of Service/Admission _____

Subscriber's ID# _____ Last Date of Service _____

Patient Name _____ Claim# _____

Patient DOB _____ Total Charges _____

Patient Account # _____

Details of Request

If submitting a corrected claim, specify the correction. Please attach supporting documents related to the request.

(Continues)

Mail Completed Forms to:

- Physicians/Healthcare Professionals may mail this completed form to:
  Horizon BCBSNJ, PO Box 199, Newark, NJ 07101-0199
- Institutional Providers may mail this completed form to:
  Horizon BCBSNJ, PO Box 1770, Newark, NJ 07101-1770
- Behavioral Health Providers may mail this form to:
  Horizon Behavioral Health Complaints and Appeals, PO Box 10191, Newark NJ 07101-3189
- Mail all SHBP/SEHBP inquiries to:
  Horizon BCBSNJ SHBP Claim Appeals/Inquiries, PO Box 820, Newark NJ 07101-0820
- Mail all FEP inquiries to:
  Horizon BCBSNJ, PO Box 656, Newark, NJ 07101-0656
- Mail all BlueCard inquiries to:
  Horizon BCBSNJ, PO Box 1301, Neptune, NJ 07754-1301

Visit our webpage for information on your appeal rights.

This Section for Horizon BCBSNJ Internal Use Only

Amount Paid _____

Payee

☐ Provider ☐ Subscriber

Penalty Against

☐ Provider ☐ Subscriber

Deductible _____ Check# _____

Copayment _____ Check Amount _____

Coinsurance _____ Check Status _____

Claim# _____ Date Cashed _____

Claim Process Date _____ Horizon Representative Name _____

Service Request # _____ Date of Horizon Response _____

Details of Horizon Response
