



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

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