



Provider Correspondence Form

Date _____

For State of Mississippi inquiries, mail to:

State Health Plan
P O Box 23071
Jackson, MS 39225-3071

For all other inquiries, mail to:

Blue Cross & Blue Shield of Mississippi
P O Box 1043
Jackson, MS 39215-1043
Fax: 601-664-5003

Form Completion Instructions

- Complete one Provider Correspondence Form for each request.
- Incomplete forms cannot be processed.
- For Medical Documentation complete Sections A, B & C.
- For Appeals use the Electronic Appeals tool on *myAccessBlue*.

A. Patient Information *(Always Complete All Fields)*

Member is insured by: State of Mississippi Federal Employee Program
 Out of State BCBS Plan Blue Cross & Blue Shield of Mississippi

Patient Name: _____ Date of Birth: _____

Subscriber ID Number with Alpha Prefix/Suffix: _____ Patient Account #: _____

Date of Service: _____ Claim Number: _____ Total Charge: _____

If more than one claim is involved, please list date of service, claim number and total charge on separate sheet and attach.

B. Provider Information *(Always Complete All Fields)*

Provider Name: _____ BCBS Provider Number: _____

Provider Address: _____ Tax ID #: _____

Contact Name/Title: _____ NPI #: _____

Contact Address: _____

Telephone #: _____ Ext.: _____

C. Submission of Requested Medical Documentation

- EDI Error 318 Received – Use of modifier requires documentation.
- Medical Records requested. (Attach copy of the request letter.)

Attach additional details and documentation as needed.