bac

CLAIMS STATUS REQUEST FORM

INSTRUCTIONS: PLEASE COMPLETE ONE FORM PER REQUEST AND/OR DATE OF SERVICE.
RETURN COMPLETED FORMS BY EMAIL TO: **STATUS@BACTPA.COM** OR FAX TO: **1.614.863.0184**

A. THIS SECTION TO BE COMPLETED BY PROVIDER:

PROVIDER NAME:	TAX I.D.
CONTACT PHONE NUMBER:	
MEMBER NAME (LAST, FIRST, M):	D.O.B.
BAC MEMBER I.D. NUMBER:	DATE OF SERVICE:
PATIENT'S ACCOUNT NUMBER:	CLAIM AMOUNT:
ADDITIONAL INFO./NOTES:	

B. THIS SECTION TO BE COMPLETED BY BAC:

CLAIM NUMBER:		
CHECK NUMBER:	CHECK DATE:	CHECK PAYMENT AMOUNT:
AMT. APPLIED TO DED.	AMT. APPLIED TO CO INS.	AMT. APPLIED TO CO PAY:
ALLOWANCE:	DISCOUNT:	◯ **NETWORK** ◯ **NON-NETWORK** ◯ **UCR**
ADDITIONAL INFO./NOTES:		

NOTE: PAYMENTS THAT HAVE NOT BEEN ISSUED ARE SUBJECT TO CHANGE.

EMAIL COMPLETED FORM TO BAC AT:
status@bactpa.com

OR FAX COMPLETED FORM TO BAC AT:
(614) 863-0184