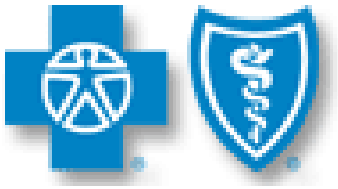

Blue Cross Blue Shield of

	Provider Fax Number:
	Date of Inquiry – Confirmation #:
NPI, Tax ID, or HMO site:	Provider Type / Specialty:
Member Group / ID #:	Patient Date of Birth:
Patient Name:	Effective Date:
Pre-existing waiting period:	Product Type:
HMO Site:	Effective Date with site:
PCP Name – effective date:	Medicare information:

COVERAGE INFORMATION

Service Zip Code:	Service Address:
Benefit Category:	Place of Treatment:
In or Out of Network:	Copayment:
Per Admit/Occurrence Deductible or Copay:	Coinsurance:
Individual Deductible:	Amount Met to Date:
Family Deductible:	Amount Met to Date:
Other Deductible:	Amount Met to Date:
Individual Out of Pocket (Stop Loss):	Amount Met to Date:
Family Out of Pocket (Stop Loss):	Amount Met to Date:
Benefit Maximum:	Amount Met to Date:
Lifetime Maximum:	Amount Met to Date:
Precertification Penalty Deductible:	HCA Information:

Special Messages:	Timely Filing:

A quote of benefits is not a guarantee of payment unless otherwise required by law. All benefits are subject to the terms, conditions, limitations, and exclusions under the member's policy, including the patient's effective status on the actual date of service. *** All claims should be filed to the state in which service was rendered unless otherwise specified under the member's contract. ***