

Welcome to our new inquiry system. In order to fully assist you, we must ask you a few questions. Please supply as much information as possible, so that we are able to give you a complete and thorough response.

Your Name:

Daytime Phone Number:

Your email address:

**Please complete the following fields with information about the insured member/cardholder.**

Employee's Name:

Employer:

ID# or Social Security Number:

**Please complete the following if you are questioning a specific claim.**

Date of Service:

Provider's Name:

(Example: City Hospital or Dr. Smith):

City where provider is located:

Dollar Amount of the Claim:

Claim Number if available: