

**WRIGHT STATE UNIVERSITY  
HEALTH BENEFIT INQUIRY FORM**

**ITEM 1 EMPLOYEE INFORMATION**

Employee Name: \_\_\_\_\_ Medical ID Number: \_\_\_\_\_  
Employee Date of Birth: \_\_\_\_\_ (Correct Prefix + Emp. SSN)  
Your Preferred Method of Contact (e.g., e-mail, fax, mail or phone): \_\_\_\_\_  
Email Address, Fax/Phone Number or Mailing Address: \_\_\_\_\_

**ITEM 2 CARRIER INFORMATION/INQUIRY CONCERN**

- |  |   |
|--|---|
| <input type="checkbox"/> Anthem Blue Preferred Primary (HMO) | <input type="checkbox"/> Provider Bill                                  |
| <input type="checkbox"/> Anthem Blue Access (PPO)            | <input type="checkbox"/> Explanation of Benefits Statement from Carrier |
| <input type="checkbox"/> Anthem Blue Traditional             | <input type="checkbox"/> Other - Please Specify _____                   |
| <input type="checkbox"/> Delta Dental Plan of Ohio           | _____   |
| <input type="checkbox"/> Vision Service Plan                 |   |

Phone No. of Person Contacted: \_\_\_\_\_  
Date Carrier Contacted: \_\_\_\_\_  
Customer Service Person Contacted: \_\_\_\_\_  
Response Provided by Customer Service Person: \_\_\_\_\_

**ITEM 3 PATIENT INFORMATION (Self or Dependent)**

Patient Name: \_\_\_\_\_ Date of Service: \_\_\_\_\_  
Patient Date of Birth: \_\_\_\_\_ Name of Provider: \_\_\_\_\_  
Amount Billed: \_\_\_\_\_

**Description of Concern/Inquiry:**