



Medical Record Routing Form

Complete this form online and print. Please allow 30 days for medical record reviews.

Patient Information

Member First Name <First name>
Member Last Name <Last name>
Contract Number
(From ID Card - Include three digit prefix) <999999999>
Claim Number <12345678901234567890123456>
Date(s) of Service <mm/dd/yyyy – mm/dd/yyyy>

Brief reason for record review request

Please print and complete. Attach the documentation and fax or mail the information to the fax number or address indicated on the medical record routing form. 100 pages or less may be faxed.

****Please note when submitting medical records: Submit the documentation needed to support the service provided to the member. Complete medical records are not routinely required and should only be submitted when requested.**

Do not attach a copy of the claim form. Please mail or fax this form with the medical records to:

Blue Cross and Blue Shield of Nebraska P.O. Box 261273 Plano, TX 75026	Or fax 100 pages or less to: Blue Cross and Blue Shield of Nebraska Medical Records 1-210-568-4364
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This communication may contain confidential Protected Health Information. This information is intended only for the use of the individual or entity to which it is addressed. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is **STRICTLY PROHIBITED** by Federal law. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.