pbH
Piedmont Behavioral Healthcare

This form is for unpaid claims only.

Claim Inquiry/Correction Form

Provider Name: _____ **Provider #:** _____ **Date:** _____
Submitted by (please print): _____ **Phone #:** _____
Email Address: _____ **Provider Fax Number:** _____

Consumer	Claim #If Applicable	SS# or DOB	Service Date	Billing Code	Claim Submission Date	Reason for Inquiry/Corrections

Processed by: _____ **Date:** _____
PBH Fax Number: 704-721-7010

Creating solutions, One person at a time