

PAYMENT INQUIRY FORM

Please fill in the appropriate information to expedite payment and/or a reply for the services listed. List only one claim on this form. Please bear down, and if using provider stamp - STAMP EACH COPY OF FORM.

PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	PATIENT'S DATE OF BIRTH	INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	INSURED'S I.D. NO.
OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)	CONDITION WAS RELATED TO: PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> ACCIDENT DATE _____	INSURED'S GROUP NO. INFORMATION NEEDED FROM THE FOLLOWING: <input type="checkbox"/> BLUE CROSS <input type="checkbox"/> NATIONAL ACCOUNTS <input type="checkbox"/> BLUE SHIELD <input type="checkbox"/> NYNEX <input type="checkbox"/> COMPREHENSIVE <input type="checkbox"/> INTERPLAN BANK <input type="checkbox"/> MAJOR MEDICAL <input type="checkbox"/> F.E.P. <input type="checkbox"/> MEDI-COMP <input type="checkbox"/>

DATE OF SERVICE FROM TO	PLACE OF SERVICE	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	DIAGNOSIS CODE	CHARGES	DAYS OR UNITS	LEAVE BLANK

REASON: <input type="checkbox"/> PLEASE ADVISE STATUS OF CLAIM <input type="checkbox"/> PLEASE ADJUST _____ IS INCORRECT: SHOULD BE _____ <input type="checkbox"/> PLEASE REVIEW DENIAL <input type="checkbox"/> ALLOWANCE	TOTAL CHARGE AMOUNT PAID BY OTHER INS.
COMMENTS:	PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME ADDRESS ZIP CODE AND TELEPHONE NO. BILLING PROV. I.D.

SIGNATURE: _____ DATE: _____

REPLY:

<input type="checkbox"/> NO RECORD - SUBMITTED FOR PROCESSING	<input type="checkbox"/> PROCESSED
<input type="checkbox"/> NO RECORD - PLEASE RESUBMIT	<input type="checkbox"/> REVIEW COMPLETED - DENIAL UPHELD
<input type="checkbox"/> CLAIM CURRENTLY IN PROCESS	<input type="checkbox"/> REVIEW COMPLETED - WILL ADJUST
<input type="checkbox"/> WILL ADJUST	

COMMENTS:

SIGNATURE: _____ DATE: _____