



HEALTHY INDIANA PLANSM
Health Coverage = Peace of Mind

Provider Inquiry Form

Mail To: MDwise HIP Claims Department
1200 Madison Avenue
Suite 400
Indianapolis, IN 46225
1-800-356-1204 or 317-630-2831

Fax To: 317-822-7535
of Pages _____

Date of Inquiry: _____
Provider Name: _____
Group Name: _____
Provider E-mail Address: _____

Contact Name: _____
Return Fax Number: _____
Provider Phone Number: _____
Provider NPI: _____

Please do not use this form for appeals.

Inquiry Type: _____ Claim Status _____ Dispute Status _____
(Circle only one)

Member Name	RID #	DOS	Amount Billed	Claim Type: Prof or Inst
Provider Notes:				
MDwise Response:				

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MDwise Response:				

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