Hoosier CARE CONNECT

Provider/Claim Status Inquiry Form

Fax To: 317-822-7444
# of Pages_____

Phone: 1-800-356-1204 or 317-630-2831

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.

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

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

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

HHW-HIPP0243 (3/13)
HCCP0027 (3/15)

MDwise