Provider/Claim Status Inquiry Form

Fax To: 855-269-1843

# of Pages_____

Phone: 855-417-5615

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	Member ID	DOS	Amount Billed	Claim Number: Prof or Inst
Provider Notes:				
MDwise Response:				

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