

# 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.
	CONDITION WAS RELATED TO:	INSURED'S GROUP NO.
OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)	PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/>  ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>  ACCIDENT DATE _____	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		DIAGNOSIS CODE	CHARGES	DAYS OR UNITS	LEAVE BLANK
		PROCEDURE CODE (IDENTIFY                      )	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)				

<b>REASON:</b> <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. _____  PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME ADDRESS ZIP CODE AND TELEPHONE NO. _____  BILLING PROV. I.D. _____
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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: \_\_\_\_\_