Claim Status Inquiry Form

Instructions:

Complete the form below and fax to 541-266-0141. Please allow **45 days** from the original date of submission before inquiring on the status of a claim. Please provide the member's **Medicaid ID**, the **Date of Service**, the **Claim Type** (P or H) and the total **Billed Amount** for the claim. Advanced Health staff will complete the remaining fields and fax the form back to the you. Please allow 5 business days for a response.

If you have any questions regarding this form, please contact our claims department at 541-269-0567.

Provider Name:		**Provider Fax #:**		**Date Submitted:**	
Contact Name:		**Contact Phone #:**		**Date Returned to Provider:**	

Member's Medicaid ID	Date of Service	Billed Amount	Claim Type [1]	Claim Status [2]	Claim Number	Date Received	EOB Date[3]	Check #

[1] Please indicate either **P** for professional claims submitted on a CMS1500 or **H** for institutional claims submitted on a UB04.
[2] Possible claim statuses are: **NR** (Not Received), **IP** (In Progress), **PD** (Paid or capitated), **DN** (Denied), **RV** (Reversed), **XX** (Please complete all required fields).
[3] Please refer to your EOB for the appropriate date. Replacement EOB's can be provided (to the original provider only) upon request by calling 541-269-0564.