

# Provider Claim Inquiry Request

**NOTE: THIS FORM SHOULD NOT BE USED TO SUBMIT A PROVIDER DISPUTE REQUESTING A RECONSIDERATION OF A CLAIM DENIAL, ADJUSTMENT, OR CONTEST; REQUEST FOR REIMBURSEMENT OF OVERPAYMENT; OR OTHER CONTRACT ISSUE. FOR PROVIDER DISPUTES, USE THE PROVIDER DISPUTE RESOLUTION REQUEST FORM.**

**INSTRUCTIONS — PLEASE READ CAREFULLY AND CHECK OFF EACH ITEM**

- Please complete the form in its entirety. Incomplete requests will be returned to your office.
- Please be specific when completing the "Reason for Inquiry" section of this form.
- Please attach a copy of the original CMS 1500 or UB-04 claim form.
- Please use the "Provider Dispute Resolution Request" form to dispute a claim denial, adjustment, or contract issue.
- Please mail the completed form with all attachments to the address shown below.

**Please mail the completed form to:** PromiseCare Medical Group  
ATTN: Claims Customer Service  
890 W. Stetson Ave.  
Hemet, California 92543

**PROVIDER INFORMATION**

PROVIDER NAME		PROVIDER TAX ID #	
PROVIDER ADDRESS		STATE LICENSE # (IF APPLICABLE)	
CONTACT NAME (PLEASE PRINT)	PHONE NUMBER	FAX NUMBER	
CONTACT SIGNATURE		CONTACT TITLE	

**GROUP**

- |   |                                    |   |
|---|------------------------------------|---|
| <input type="checkbox"/> HCMG           | <input type="checkbox"/> Menifee   | <input type="checkbox"/> Temecula       |
| <input type="checkbox"/> Prime Partners | <input type="checkbox"/> Val Vista | <input type="checkbox"/> Family Seniors |

**CLAIM INFORMATION**

- Single Claim       Multiple Claims (complete attached spreadsheet)      Number of Claims: \_\_\_\_\_

MEMBER NAME	HEALTH PLAN
MEMBER ID #	DATE OF BIRTH
DATE OF SERVICE	TOTAL BILLED CHARGES
PATIENT ACCOUNT #	DATE CLAIM WAS SUBMITTED

**INQUIRY TYPE**

- |   |  |
|---|--|
| <input type="checkbox"/> Status of Claim  | <input type="checkbox"/> Assistance in determining member responsibility                 |
| <input type="checkbox"/> Clarification on calculation of payment  | <input type="checkbox"/> Corrected billing (additional charges not previously submitted) |
| <input type="checkbox"/> Resubmission of "Contested" claim with missing information (requested info attached) | <input type="checkbox"/> Other: _____  |

**REASON FOR INQUIRY**  
*Please indicate the reason for inquiry and provide a detailed description.*

**CLAIMS STATUS — TO BE COMPLETED BY PROMISECARE MEDICAL GROUP**

Claim has been received and is in process.

Claim was paid on \_\_\_\_\_ Check # \_\_\_\_\_ Amount \$ \_\_\_\_\_ (See attached EOB)

Claim was previously denied. (Please see attached EOB)

Claim is pending for the following information: \_\_\_\_\_

Other: \_\_\_\_\_

Verified by: \_\_\_\_\_ Date: \_\_\_\_\_