Physicians Health Plan

CLAIM INQUIRY FORM

CLEAR FORM

Date of Request:	**Provider Name:**
Member Name:	**Provider Number:**
Member Number:	**Contact Name:**
Date of Service:	**Contact Number:**
Claim Number:	**Provider Relations Coordinator's Name:**

Please choose the appropriate box and describe below:

☐ **Incorrect Payment–** Rate expected $_____

☐ **Line Denial** (or Code Denial)- Code_____

☐ **Claim Denial–** Denial Reason_____

☐ **Code Bundling–** Bundled codes_____

Please provide a detailed description of your inquiry:

Please Send Inquiry Request To:

Physicians Health Plan
PO Box 30377
Lansing, MI 48909
Or Fax to: (517) 364-8411