CLEAR FORM

Medical Records Submission Form

Physicians Health Plan

NOTE: *Use this form is for the purpose of submitting Medical Records and/or additional information as requested. Do not use this form for claim inquiries, disputes or appeals.*

Date of Submission:

Provider Name:

Member Name:

Provider Number:

Member Number:

Address:

Date of Service:

Claim Number:

Contact Name and Number:

Please choose the appropriate box and description below:

☐ **Medical Records Request**

- Explanation of Payment (EOP)
  Denial codes: **QS5, QP2, QR2 QG7, QL1, QN3, QN4, QN5, QN8, QR6, QR7, RG6, RG7, RL1, RN3, RN4, RN5, RN8, RR2, RS5, Q21**
  Send to: **Change Healthcare**

☐ **Itemization / Implant Log Request**

- Explanation of Payment (EOP)
  Denial codes: **QR4, QN6, QN7, RN6, RN7, RR4**
  Send to: **Change Healthcare**

Change Healthcare

Fax: 949.234.7603 or 952.949.3713
Email: medicalrecords@changehealthcare.com
Mail: Change Healthcare
5755 Wayzata Blvd
St. Louis Park, MN 55416

☐ **Medical Records Request**

- Explanation of Payment (EOP)
  Denial codes: **490, 590, 690, 4G5**
  Send to: **PHP**

☐ **Itemization/Invoice Request**

- Explanation of Payment (EOP)
  Invoice Denial codes: **430**
  Itemization Denial Codes: **482, 4F9, 5F9, 682**
  Send to: **PHP**

PHP

Mail: Physicians Health Plan
PO Box 853936
Richardson, TX 75085-3936

☐ **Other** (please provide detailed information for your request):

- Send to: **PHP**