

**Physicians Health Plan
CLAIM INQUIRY 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