

Medical Records Submission Form



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

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**