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**
  Send to: **Change Healthcare**

☐ **Itemization Request**

- Explanation of Payment (EOP)
  Denial codes: **QR4**
  Send to: **Change Healthcare**

Change Healthcare

Fax: 952.949.9713 or 949.234.7603
Mail: Change HealthCare
5720 Smetana Drive, Suite 400
Minnetonka MN 55343

☐ **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**

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