CLAIM STATUS/APPEAL REQUEST FORM

DATE OF INQUIRY: _____

PROVIDER OF SERVICE: _____

TAX ID: _____

REQUESTER: _____ _____
FIRST NAME LAST NAME

CONTACT NUMBERS: _____ _____
PHONE FAX

PATIENT NAME	PROVIDER/PATIENT ID NUMBER	DATE(S) OF SERVICE	CLAIM AMOUNT	DATE CLAIM SUBMITTED

METHOD OF CLAIM SUBMISION: ☐ MAIL ☐ ELECTRONIC

REQUESTING: ☐ CHECK NUMBER ☐ CHECK CLEAR DATE
(If Applicable) ☐ EXPLANATION OF BENEFITS ☐ CHECK MAILING ADDRESS

PURPOSE OF INQUIRY: ☐ CLAIM STATUS ☐ APPEAL (PLEASE LIST REASON)

COMMENTS/INFORMATION: _____

_____

PLEASE FAX OR EMAIL THE COMPLETED FORM TO 904.473.1218 OR CLAIMSTATUS@MEDINT.COM

90 Fort Wade Road
Ponte Vedra, FL 32081

ph 904.473.1200

www.medint.com