

**PROVIDER INQUIRY FORM**  
**CCStpa**

One form per inquiry

Today's Date: \_\_\_\_\_ Provider ID#: \_\_\_\_\_ Provider Name: \_\_\_\_\_

Your Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Return Address: \_\_\_\_\_

Patient Account Number: \_\_\_\_\_ NPI (National Provider Identifier) Number: \_\_\_\_\_

Member ID#:	Patient Name:	Claim #:
Group #:	Billed Charge:	Service Dates (all):

**INQUIRY** (Status check or claim adjustment)

Fax all inquiries to (651) 662- 2745

- Status Check: *Please wait 30 days from the date you submitted the claim before checking on the status of the processing.*
- Claim Adjustment Request (please complete appropriate information)
- |   |  |
|---|--|
| <input type="checkbox"/> Wrong provider # : Void original/provider resubmit | <input type="checkbox"/> Change diagnosis _____ to _____           |
| <input type="checkbox"/> ID# should be: _____                               | <input type="checkbox"/> Add modifier ____ to procedure code _____ |
| <input type="checkbox"/> Service was referred, case #: _____                | <input type="checkbox"/> Change procedure _____ to _____           |
| <input type="checkbox"/> Patient should be: _____                           | <input type="checkbox"/> Not our patient, please recoup claim.     |
| <input type="checkbox"/> Services should not have been billed because _____ |  |
| <input type="checkbox"/> Overpayment / Underpayment:                        |  |
| <input type="checkbox"/> Other carrier paid (include EOB)                   |  |
| ○ Medicare paid (include EOB)   | ○ No fault auto paid   |
| ○ Worker's Compensation paid  | ○ Other: _____   |

**APPEAL**

**Minnesota Providers:** Use the Administrative Uniformity Committee (AUC) form to request a reconsideration of a previously adjudicated claim for which there is no additional or corrected data to be submitted, visit their website at:  
<http://www.health.state.mn.us/auc/index.html>

Fax the AUC form to (651) 662- 2745

**All other Providers:** Use the Appeal form on our website

An appeal is a denial, reduction, termination of, or a failure to provide or make payment (in whole or part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment.

Indicate here if multiple related inquiries are being submitted for the same member.  
Specify number in \_\_\_\_ of \_\_\_\_ format (e.g. 1 of 5, or 3 of 10).