CLAIMS FOLLOW-UP / INQUIRY REQUEST FORM

NOTE: This form should NOT be used if you wish to submit a Provider Dispute requesting Physicians Medical Groups' reconsideration of a claim denial, adjustment, request for reimbursement of overpayment, or other contract issue. For Provider Disputes, use the Provider Dispute Resolution Request Form.

Send to:

Physicians Medical Group of San Jose
1565 Mabury Road Suite D
San Jose, CA 95133

Sent by:	**PROVIDER TAX ID #:**
Provider Name: (Hospital/facility/physician)	
Provider Address:	

Patient Name:		**Date of Birth:**
Member's Health Plan:	**Member ID Number:**	**Claim ID Number:** (If known)

Service "From/To" Date:	**Original Claim Amount Billed:**	**Date Sent:**

INQUIRY TYPE - *Indicate reason for inquiry and provide a detailed description.*

☐ Resubmission of "contested" claim with missing information. (requested individual claim documents attached)

☐ Status of Claim (i.e. no receipt of payment) - *see BEFORE SENDING A REQUEST notice below.*

☐ Clarification on calculation of payment

☐ Assistance on determining member responsibility

☐ Corrected Billing (additional charges previously not submitted)

Contact Name (please print)	**Title**	( ) **Phone Number**
Signature	**Date**	( ) **Fax Number**

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**

[ ] **SPREADSHEET ATTACHED**
[ ] **INDIVIDUAL CLAIM ATTACHED**

BEFORE SENDING A REQUEST: Please allow a reasonable time for Claims to be processed before submitting an Inquiry. Claims may also be viewed on-line at http://www.pmgmd.com