Providence Health Plan

CLINICAL EDIT INQUIRY FORM

*****ONE CLAIM PER FAXED INQUIRY*****

Sender Name:	Date:
Sender Fax:	Sender Phone:
Sender Contact Email:	
Provider Name:	# Pages: (including cover)
Provider Group name:	Claim #:
Member Name:	DOS:
PHP Member ID #:	CPT Code:
Additional Notes:	

Please visit ProvLink to review the full list of our Payment Policies and Medical Director Edits.

Please include the following with your inquiry:

1. Chart notes for date of service that support all procedures.
2. Letter of explanation for the inquiry.

If the claim denies for the codes listed directly below, **fax to (503) 574-8609 or (888) 397-0003.**

☐ t04	☐ u03	☐ u14	☐ z58	☐ ____
☐ t15	☐ u11	☐ z45	☐ z66	
☐ t18	☐ u13	☐ z46	☐ z77	

If the claim denies for chart notes or any of the codes listed below, **fax directly to Healthcare Services at (503) 574-8179.**

☐ p03	☐ u09	☐ u31	☐ z37	☐ z79
☐ p04	☐ u21	☐ u42	☐ z41	☐ z80
☐ t07	☐ u24	☐ u43	☐ z78	☐ ____