Please use this form when requesting one of the following types of review:

Medicare Remit:

Primary Payer Remit:

Medicaid Managed Care Retraction:

Two-Year Waiver:

Client Name:

CIN:

Claim Number:

Date(s) Of Service:

Provider/Facility Name:

Billing Provider MMIS#:

Billing Provider NPI#:

Point of Contact:

Phone Number:

Email:

Mailing Address:

Comment Section