CLAIM INQUIRY FORM

This inquiry form is used to assist us in reconsidering your original claim. Please attach this form to all corrected claims and/or medical records as required. Inquiries with incomplete or missing information will be returned to the provider. Provide details regarding the inquiry in the space provided below. This form may be reproduced as necessary. Additional forms are also available at www.dakotacare.com. Thank you for your cooperation.

Send your inquiry form to:
DAKOTACARE
2600 West 49th Street
Sioux Falls, SD 57105-6575

Provider Information

Provider Name ______________________________

Contact Person ______________ Phone Number ______________

Address ______________________________

Email Address ______________________________

Member/Patient Information

Member/Patient Name ______________________________

Member/Patient ID # ______________________________

Date(s) of Service ______________________________

Claim Number(s) ______________________________

Reason for Inquiry (attach corrected claim):

- ☐ ** Bundling/Unbundling (if other than lab/x-ray, attach medical records)
- ☐ ** Modification of ICD-9CM and/or CPT/HCPCS code (attach medical records)
- ☐ ** Modifier Addition/Deletion (attach medical records for modifiers 25, 57, and 59)
- ☐ ** Preventive Service (attach medical records)
- ☐ ^^ Deductible/Coinsurance/Copayment review
- ☐ ^^ Maximum Allowable/Reimbursement Review. Specify code(s)

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- ☐ ^^ Overpayment
- ☐ ^^ Denial Inquiry (i.e. benefits, duplicate, termination, etc.)
- ☐ ^^ Other (specify) ______________________________

Third Party Liability

- ☐ Workers' Compensation
- ☐ Coordination of Benefits
- ☐ Payment received from an outside liability/medical payments carrier

Details

For Internal Use Only:
** TPL COR
^^ CS COR