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
P.O. Box 7406
Sioux Falls, SD 57117-7406

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)

_____

- ☐ ^^ 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