ACS State Healthcare
1440 Kapiolani Blvd., Ste. 1400
Honolulu, HI 96814-369

MEDICAID CORRESPONDENCE INQUIRY FORM

1. Date of Inquiry	2. Provider Name (Last, First, Middle Initial)		
3. Provider Number	4. Address ❑ Pay to Address ❑ Service Address		
5. Telephone Number	6. Name of Contact		7. Correspondence Number
8. Claim Number (if applicable)	9. Purpose of Inquiry: ❑ Questionable Payment ❑ Adjustment/Correction ❑ Claims Status ❑ Claims Filing Procedure ❑ Other:		
10. Patient Name	11. Patient ID Number		12. FM Code
13. Dates of Service	14. Payment Date	15. Charge	16. Allowance
17. Remarks			

18. Response to Provider:
- ❑ Claim Paid on ____
- ❑ Denied on ____ Reason: ____
- ❑ Claim Reviewed, Maximum payment made.
- ❑ Adjustment claim initiated.
- ❑ Please submit claim with ____
- ❑ Patient name and ID # not in DHS files.
- ❑ Claim is in the processing system. Please allow additional processing time.
- ❑ Referred to DHS for determination and response directly to you.
- ❑ Unable to match above claim data with computer file data. Please submit copy of claim.

Comments: ____

Shaded area for Medicaid use only

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