



**INDIANA HEALTH COVERAGE PROGRAMS
ADMINISTRATIVE REVIEW REQUEST**

Date		For HP Internal Use Only – LCN	
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Provider name:		NPI/LPI	
Contact name:		Telephone number/ Email address	

REASON FOR ADMINISTRATIVE REVIEW REQUEST (please mark applicable box below)

<input type="checkbox"/>	Request reconsideration of claim payment or denial
<input type="checkbox"/>	Request review of NCCI denial
<input type="checkbox"/>	Request review of assistant surgeon modifier AS denial (include operation report)

Claim Information (include all previous filing/adjustment attempts)

Member name		Member number (RID)	
Date of service		Billed amount	
Date paid/denied		ICN	
Date paid/denied		ICN	
Date paid/denied		ICN	

Please provide a detailed description of the reason for your request (attach all pertinent documentation including Remittance Advice statements, insurer EOB, medical records, and so on):

Retain a copy for your records and mail original to:

HP Written Correspondence
PO Box 7263
Indianapolis, IN 46207-7263