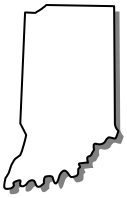
Indiana Health Coverage Programs



INDIANA HEALTH COVERAGE PROGRAMS INQUIRY

Date _____ | **For HP Internal Use** **LCN#**_____

Provider name _____ **Provider number** _____

Provider address _____

_____

_____

Member name _____ **Member identification number (RID)** _____

Date of service _____ **Total amount of charges** _____

Date billed _____ **ICN from previous bills** _____

Date paid/denied _____

Reason for inquiry _____

_____

_____

_____

_____

_____

_____

_____

_____

Signature

For HP Internal Use **Response**

_____

_____

_____

_____

_____

_____

_____

_____

Signature of analyst

Retain a copy for your records and send the original to:

Provider Written Correspondence
HP
P. O. Box 7263
Indianapolis, IN 46207-7263