Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200153 DECEMBER 21, 2001

To: **All Providers**

Subject: **New Written Correspondence Inquiry Form**

Overview

This bulletin introduces the new *Indiana Health Coverage Programs Inquiry* form, used to submit written correspondence to EDS. This single copy form replaces the previously used NCR triplicate form. The new form prompts providers to complete pertinent information used to process an inquiry. Complete information reduces turnaround time for responses, and minimizes the need for follow-up contacts to obtain additional information. Although this form is not required for inquiries, it is free of charge and can be used immediately.

How to Obtain Forms

A copy of the *Indiana Health Coverage Programs Inquiry* form is attached to this bulletin and can be copied. The form is also available for print or download from the IHCP Web site at www.indianamedicaid.com. It is no longer necessary to request *Indiana Health Coverage Programs Inquiry* forms from EDS.

How to Submit Forms

The *Indiana Health Coverage Programs Inquiry* form should be used to submit a written inquiry to EDS. Include only one inquiry per form. Send completed inquiry forms to the EDS Written Correspondence Unit at the following address:

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

All documentation associated with an inquiry, such as remittance advice statements and claim forms, should be attached to the completed *Indiana Health Coverage Programs Inquiry* form. The Written Correspondence Unit tracks all requests; however, providers are advised to retain copies of submitted requests for their files.

Additional Information

Questions about the information in this bulletin should be directed to the EDS Customer Assistance Unit at (317) 655-3250 in the Indianapolis local area or 1-800-577-1276.

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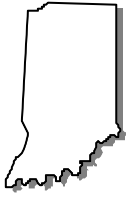

INDIANA HEALTH COVERAGE PROGRAMS INQUIRY

Date ______________________

For EDS Internal Use **CCN#**________________________________

Provider name ______________________ **Provider number** ______________________

Provider address ______________________

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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 ______________________

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Signature

For EDS Internal Use **Response**

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Signature of analyst

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

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

Written Inquiry Form # 370-009
Date: December 21, 2001