Confidential

Independent Health

PROVIDER INQUIRY FORM

Today's Date: _____

Provider Name: _____ NPI/ID Number: ☐☐☐☐☐☐☐☐☐☐

Billing Address: _____ Phone #: _____ Ext: _____

City: _____ State: _____ Zip: _____ Contact Name: _____

Member Name: _____ Date of Service: _____

Member ID #: ☐☐☐☐☐☐☐☐☐☐ Acct: # _____

Claim #: ☐☐☐☐☐☐☐☐☐☐☐☐☐

To assure a prompt response, please check the most appropriate box:

☐ Coordination of Benefits information attached. (e.g.: EOB, EOMB)

☐ Requesting reconsideration of previously processed claim, supporting documents attached. (e.g.: Op Reports, Invoice, Corrected Claim, Billing History)

☐ Payment withdrawal request

When submitting a corrected claim, please include all services that were rendered. Please DO NOT submit only the claim lines that are corrected/added/changed.

Provider Comments: _____

_____

_____

_____

Please submit your inquiry to the appropriate address:

First time claim submission (with or without COB)
Independent Health
Claims Department
P.O. Box 9066
Buffalo, NY 14231

Other COB Inquiries
Independent Health
Coordination of Benefits
P.O. Box 621
Buffalo, NY 14231

All Other Provider Inquiries
Independent Health
Provider Relations
P.O. Box 1017
Buffalo, NY 14231