April 2007

Montana Healthcare Claim Inquiry Form

Provider Name ______________________________
Contact Person ______________________________
Address ______________________________
Date ______________________________
Phone Number ______________________________
Fax Number ______________________________

For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Billing number ______________ Client number ______________ Date of service ______________ Total billed amount ______________ Date submitted for processing ________	ACS Response: ______________
Billing number ______________ Client number ______________ Date of service ______________ Total billed amount ______________ Date submitted for processing ________	ACS Response: ______________
Billing number ______________ Client number ______________ Date of service ______________ Total billed amount ______________ Date submitted for processing ________	ACS Response: ______________

Mail to:

Provider Relations
P.O. Box 8000
Helena, MT 59604

Fax to: (406) 442-4402