STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

CLAIM INQUIRY FORM

Attach a red & white, one-page claim form and any applicable documentation. If you have previously sent a claim for review, please be sure to include additional documentation not previously sent to support your request. Please include detailed processing instructions in the Inquiry field. Return the completed form to the address below. A completed form is required for each submitted claim.

SEND COMPLETED FORM TO:

Attn: Provider Services
Oklahoma Health Care Authority
PO Box 18506, Oklahoma City, OK 73154

FORM MUST BE PLACED ON TOP OF CLAIM

PROVIDER INFORMATION

Name & Address:	Provider Number: _____ Group Number (if applicable): _____ Telephone: _____ Contact Name: _____ Please print.

CLAIM INFORMATION

Member Name	Member ID Number	Date of Service	Related ICN

INQUIRY: (Please list specific reasons why claim needs/requires special processing.)

Printed Name: _____ Signature: _____	Date:

For Internal Use Only

FORM MUST BE PLACED ON TOP OF CLAIM