INDIANA HEALTH COVERAGE PROGRAMS
ADMINISTRATIVE REVIEW REQUEST

Date		For Gainwell Internal Use Only – LCN	

Provider name:		NPI/IHCP Provider ID	
Contact name:		Telephone number/ Email address	

REASON FOR ADMINISTRATIVE REVIEW REQUEST (please mark applicable box below)

	Request reconsideration of claim payment or denial
	Request review of NCCI denial
	Request review of assistant surgeon modifier AS denial (include operation report)

Claim Information (include all previous filing/adjustment attempts)

Member name		Member ID (RID)	
Date of service		Billed amount	
Date paid/denied		ICN/Claim ID	
Date paid/denied		ICN/Claim ID	
Date paid/denied		ICN/Claim ID	

Please provide a detailed description of the reason for your request (attach all pertinent documentation including Remittance Advice statements, insurer EOB, medical records, and so on):

Retain a copy for your records and mail original to:

Gainwell – Written Correspondence
PO Box 7263
Indianapolis, IN 46207-7263