INDIANA HEALTH COVERAGE PROGRAMS
WRITTEN INQUIRY

Date		For Gainwell Internal Use Only – LCN	

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

REASON FOR REQUEST (please mark applicable box below)

	General Inquiry (not related to a specific claim) – Questions about member eligibility, benefit limits, coverage/policy information, third-party liability
	Claim Inquiry (not claims status) – Questions about the adjudication of a specific claim
	Requests for Remittance Advice or other financial information
	Refund/Accounts Receivable Inquiries – Requests for additional information about a refund or an accounts receivable
	Other (please specify)

Please provide a detailed description of the reason for your inquiry:

Retain a copy for your records and mail original to:

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