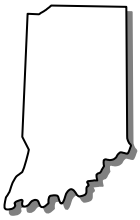
Indiana Health Coverage Programs



CLAIM ADMINISTRATIVE REVIEW REQUEST

(FEE-FOR-SERVICE NONPHARMACY)

Not To Be Used for Administrative Reviews Related to Prior Authorization Determinations

Date		For Gainwell Internal Use Only – LCN	

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

Reason for Claim 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 50442
Indianapolis, IN 46250-0418