CLAIM INQUIRY REQUEST

Send to:
Santé Physicians
P.O. Box 792
Fresno, CA 93712

Sent by: (Provider Name/Facility)	Provider Tax ID #:
Provider Address:	

Patient Name:		Date of Birth:
Member ID Number:	Claim Number (if known):	
Service “From-To” Date:	Original Claim Amount Billed:	Original Submission Date:

INDICARE THE REASON FOR INQUIRY AND PROVIDE A DETAILED DESCRIPTION

Inquiry Type:

- □ Resubmission of “contested” claim with missing information (document attached).
- □ Status of Claim (i.e. no receipt of payment)
- □ Clarification on calculation of payment
- □ Assistance in determining member responsibility
- □ Corrected Billing (additional charges previously not submitted)

Contact Name	Tittle	Phone Number

Signature	Date

June 1, 2021