CLAIM STATUS FORM

Date of Status_____Provider Contact/Statuses: _____

Provider Name and Tax ID: _____

Health Plan _____

Patient Name: _____

Contract/ID Number: _____

Claim Number _____

Procedure Code(s) Status: _____

Usual and Customary Charge(s): $_____

Date of Service: _____

Authorization Number: _____

Date of First Submission: _____

Reason for Claim Status: _____

_____

Additional Documentation Submitted: (YES) _____ (NO) _____

Additional Comments:

_____

_____

Status forms are to be used for underpayments, rejected claims, recoupment's/retractions.

Mail To: NORTHWOOD INC.
Attn: Claims: P.O. BOX 510
WARREN MI 48090-0510