



Northwood
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, or
recoupments/retractions only.*

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