



# CLAIM RESEARCH FORM

(Complete the attached HIPAA Form and include any supporting documents to assist in further research.)

**RESOLUTION MAY TAKE UP TO 30 BUSINESS DAYS FROM OUR RECEIPT OF CLAIM RESEARCH FORM, HIPAA FORM AND REQUESTED SUPPORTING DOCUMENTS**

Check One: Coresource Kaiser Delta Dental UHC Dental

Employee Status:

Check One: Claim Not Paid Claim Denied Incorrect Amount Paid

Active Retired – Date of Retirement \_\_\_\_\_

Today's date: / /

## EMPLOYEE INFORMATION

Employee Last Name: First:

E-Mail Address: Birth Date: / / Sex:  M  F

Street Address: Social Security Number: Phone Number: ( )

City: State: ZIP Code: Cell Phone Number: ( )

Is this claim regarding a Dependent: Yes  No

If Yes, Dependent Name: Dependent Birth Date: / /

## INSURANCE INFORMATION

*(To be completed by employee)*

PPO Coresource  HMO Kaiser Member ID Number: (Located on Insurance Card)

**Date Claim Submitted to Insurance Company: / /** **SUBMIT RESEARCH FORM WITH DATE CLAIM WAS SUBMITTED TO INSURANCE COMPANY (Date can be found on your Explanation of Benefits from your insurance company, contacting the insurance company and/or the Provider)**

## CLAIM INFORMATION

*(To be completed by employee)*

**Complete a separate Claim Research Form for each date of service**

Provider Name:  In-Network Provider  Out-of-Network Provider

Contact Name at Provider's Office:

Provider Phone Number:

Date of Service: / / Amount Billed from Provider: \$

A) Is Date of Service over 1 (one) year old?  Yes  No **If yes, 12 month timely filing rule applies.**

B) Claim in Collections?  Yes  No **If yes, speaking directly with the collection company is the employee's responsibility.**

## RESOLUTION LOG (FOR OFFICE USE ONLY)

Date Received: / / Date Responded to Employee (7 days or less) / / Initial:

Date Resolved: / / Completed By:

FAX TO: 877.876.5667