MEDICA®
Everyone Benefits®

rundate

provname
paddr1
paddr2
pcsz

RE: **mename2**
Member ID#: **grp**-**sub**-**dep**
Audit/UFE Number: **auditnbr**
Clinic Account Number: **clinacct**
Provider #: **provnbr**

We strive to improve the timely and accurate processing of your claims. The following information is required to appropriately process the recently received claim(s).

PLEASE PROVIDE THE FOLLOWING **_**x1**_ INVALID OR _**x2**_ MISSING** INFORMATION AS INDICATED BELOW.

BILLING PROVIDER:

x3 Provider NPI number.
x4 Provider Name
x5 Tax Identification Number
x6 Provider specialty # for FED ID.
x7 Provider number must be submitted in Box 33, in the Pin # Field for the CMS 1500, or Box 51 for a UB04
x8 Provider FED ID is expired/invalid for date of service

SERVICE DETAIL/ITEMIZATION:

Processor, please specify which line item code, or box found on the claim form is being referenced below:

x9 Diagnosis (ICD-9) code (s) ****freeform9****
x10 Procedure (CPT/HCPCS) code(s)/modifier(s) ****freeform10****
x11 Revenue code(s) ****freeform11****
x12 Procedure code/Wrong gender for procedure/ Provider type does not match procedure code ****freeform12****
x13 Place of Service code(s) ****freeform13****
x14 Number of Units ****freeform14****
x15 Dollar Amount ****freeform15****
x16 Date of Service ****freeform16****
x17 National Drug Code (NDC) and dosage ****freeform17****
x18 Supervising/Attending Physician name/number ****freeform18****
x19 Bill type ****freeform19****

PATIENT INFORMATION:

NOTE: Member number includes: 5-digit group number + 9-digit subscriber Social Security number + 2-digit relationship Code or Personal Medicaid Identification (PMI)

x20 Unable to identify patient as a MEDICA enrollee.
x21 The member/group ID number.
x22 The member number/group ID number is inactive for date of service.

CLAIM FORM:

x23 Please resubmit claim on CMS 1500 or UB04 claim form.
x24 Please resubmit claim with a legible copy.
x25 Itemization of Charges is needed.

OTHER: **freeform**

If you have questions or need further clarification, please call the Medica Provider Service Call Center at 1-800-458-5512.

PLEASE RETURN TO: **procflinit**

AT: Medica Claims
PO Box 30990
Salt Lake City, UT 84130