

PROVIDER INQUIRY FORM

**HP Enterprise Services
P.O. Box 2100
Frankfort, KY 40602-2100**

*Please remit both copies
of the Inquiry Form to
HP Enterprise Services*

1. Provider ID	3. Member Name (first, last)	
2. Provider Name and Address	4. Medical Assistance Number	
	5. Billed Amount	6. Claim Service Date
	7. RA	8. Internal Control Number
9. Provider's Message		
10. _____		Date
Signature		

HP Enterprise Services Response:

_____ This claim has been resubmitted for possible payment.

_____ HP Enterprise Services can find no record of receipt of this claim as indicated above. Please resubmit.

_____ This claim paid on _____ in the amount of _____

_____ This claim was denied on _____ with EOB code _____

_____ This claim denied on _____ with EOB 00294 "KenPAC Member. Referring provider ID is missing or is not the KenPAC primary physician/clinic ID for the date(s) of service."

_____ This claim denied on _____ with EOB 00295 "KenPAC Member. Billing and/or referring provider ID is not the KenPAC primary physician/clinic for date(s) of service."

_____ This claim denied on _____ with EOB 00467 "Member has other medical coverage. Bill other insurance first or attach documentation of denial from the insurance carrier."

_____ Aged claim. Please see attached documentation concerning services submitted past the 12 month filing limit.

Other: _____

Signature _____
Date _____