

## 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: \_\_\_\_\_

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Signature \_\_\_\_\_
Date \_\_\_\_\_