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Provider Inquiry Form

This form may be used to inquire about the processing, status or payment of a claim adjustment or financial transaction. It may also be used to request information on program policy or procedure.

Please follow these instructions to help us answer your question as quickly and accurately as possible:

1. Complete one form for each question.
2. Include supporting documents (claim copies, Remittance Advice copies and/or Medicare documents as appropriate). This is particularly critical when asking about Medicare related matters as the EDS office does not have copies of Medicare Remittance Advices, vouchers or other Medicare documents.
3. Provide as much information as possible in blocks 1 through 10. This information helps us identify the specific item in question and provide an answer.

1. Provider Number	3. Recipient's Name	4. Claim Status	
2. Provider Name/Address	5. Recipient's Medicaid ID No.	— Paid	
	6. Internal Control Number 	— Denied	
	7. Date of Service From: to:	8. Billed Amount	9. R/A Date
10. Specific Description of Problem			

11. Signature of Sender	12. Date
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*** EDS RESPONSE ***

EDS Representative