

**CLINICAL EDIT INQUIRY FORM**

**\*\*\*ONE CLAIM PER FAXED INQUIRY\*\*\***

Sender Name:	Date:
<b>Sender Fax:</b>	Sender Phone:
<b>Sender Contact Email:</b>	
Provider Name:	# Pages: (including cover)
Provider Group name:	Claim #:
Member Name:	DOS:
PHP Member ID #:	CPT Code:
Additional Notes:	

***Please visit ProvLink to review the full list of our Payment Policies and Medical Director Edits.***

**Please include the following with your inquiry:**

1. Chart notes for date of service that support all procedures.
2. Letter of explanation for the inquiry.

If the claim denies for the codes listed directly below, **fax to (503) 574-8609 or (888) 397-0003.**

- |                              |                              |                              |                              |                                |
|------------------------------|------------------------------|------------------------------|------------------------------|--------------------------------|
| <input type="checkbox"/> t04 | <input type="checkbox"/> u03 | <input type="checkbox"/> u14 | <input type="checkbox"/> z58 | <input type="checkbox"/> _____ |
| <input type="checkbox"/> t15 | <input type="checkbox"/> u11 | <input type="checkbox"/> z45 | <input type="checkbox"/> z66 |                                |
| <input type="checkbox"/> t18 | <input type="checkbox"/> u13 | <input type="checkbox"/> z46 | <input type="checkbox"/> z77 |                                |

If the claim denies for chart notes or any of the codes listed below, **fax directly to Healthcare Services at (503) 574-8179.**

- |                              |                              |                              |                              |                                |
|------------------------------|------------------------------|------------------------------|------------------------------|--------------------------------|
| <input type="checkbox"/> p03 | <input type="checkbox"/> u09 | <input type="checkbox"/> u31 | <input type="checkbox"/> z37 | <input type="checkbox"/> z79   |
| <input type="checkbox"/> p04 | <input type="checkbox"/> u21 | <input type="checkbox"/> u42 | <input type="checkbox"/> z41 | <input type="checkbox"/> z80   |
| <input type="checkbox"/> t07 | <input type="checkbox"/> u24 | <input type="checkbox"/> u43 | <input type="checkbox"/> z78 | <input type="checkbox"/> _____ |