RESET FORM HIGHLIGHT FIELDS PRINT FORM

Illinois Department of Healthcare and Family Services

MEDICAID CLAIM INQUIRY

If you wish to have the Department of Healthcare and Family Services determine if one of your medical bills was or should have been paid by the Department, you must fill out this form completely, sign and date it and send it to the address listed below.

You must attach evidence of pending lawsuit, threatened litigation or contact from a collection agency on behalf of a service provider. Also, attach any medical bills that you may have to help our investigation. The Department of Healthcare and Family Services will investigate your inquiry and send you a written response within 30 days. You should keep a copy of this completed form for your records.

PATIENT Information

Patient's Name:_____

Patient's Social Security Number

Your Name: _____ Phone ( ) _____

Address: _____

_____
City State Z ip

Signed: _____ Dated: _____

PROVIDER Information

Name: _____ Phone: ( )
(first/last name, or facility name)

Address: _____

_____
City State Zip

SERVICE Information

Date(s) of Service received: _____

Brief Explanation: _____

MAIL Completed Form To:

Illinois Department of Healthcare and Family Services
Bureau of Comprehensive Health Services Litigation/
Collection Review
201 S. Grand Ave. East
Springfield, Illinois 62763-0002

QUESTIONS? Contact Litigation/Collection Staff at (217)782-5565

DPA 3437 (R-7-01) IL478-2206