STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

CLAIM APPEAL AND REVIEW COVER SHEET

Attach a red & white, one-page claim form and any applicable documentation. If you have previously sent a claim for review, please be sure to include additional documentation not previously sent to support your request along with this cover sheet. Please include detailed processing instructions in the Inquiry field. A completed cover sheet, claim form and documentation is required for each appeal.

SEND COMPLETED COVER SHEET AND CLAIM FORM TO:

Attn: Provider Services
Oklahoma Health Care Authority
PO Box 18506, Oklahoma City, OK 73154

COVER SHEET MUST BE PLACED ON TOP OF CLAIM FORM

PROVIDER INFORMATION

Name & Address:	Provider Number: _____ Group Number (if applicable): _____ Telephone: _____ Contact Name: _____ Please print.

CLAIM INFORMATION

Member Name	Member ID Number	Date of Service	Related ICN

INQUIRY: (Please list specific reasons why claim needs/requires special processing.)

Printed Name: _____ Signature: _____	Date:

For Internal Use Only

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