Request for Duplicate Provider Remittance Statement

Please complete one form per request and include $20.00 non-cash payment per request. Requests will only be processed for Remittance Advices beyond 24 months. Mail completed form(s) and payment to:

Oklahoma Health Care Authority
ATTN: Central Files
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Provider Name (Last, First, MI): ____
*Provider Billing Number: ____
Mailing Address (with zip code): ____
____
Contact Person: ____
Telephone Number (with extension) ____

Paid Claims: (Complete A or B)

A.
Warrant #: ____________________________
Issue Date: ____________________________
* Pay to Provider Number: ______________

B.
Deposit Date: ___________________
Deposit Amount: ________________
* Pay to Provider Number:_________

Denied Claims:
Medicaid Client ID #: ___________________
*Pay to Provider Number: ________________
Date of the Service:___________________
Date of Denial:______________________

If you filed your claim via Electronic Media (EMC), please include EMC transmittal #: ______________________

*** Provider Numbers as of Date of Service**

Incomplete requests will be returned.
As stated under the Federal Privacy Act, information will not be released to collection agencies.

Please allow 3-4 weeks for response.

Agency Use:
Date Received/Initial:____________/__
Date Completed: __________________
Check Number: ___________
Mailed: __________________