



**Status Checks**

Please Fax This Form to 1-866-504-6356

Provider Fax Number:								
	Provider Number/Tax ID	Member Name	Member ID Number	Date of Service	Total Amount Billed	Remittance Advice Date	Paid Amount	Response
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

**Disclaimer:** These benefits are based on the information you have given us today. Due to possible contract changes or policy cancellation, final determination will be made when claims are received. This information is subject to change based on eligibility and is ultimately to be determined by the State.

<b>Signature:</b>	<b>Date:</b>
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