



Date Submitted: ____/____/____

Pages Attached: _____

HEALTH CARE PROVIDER CLAIM INQUIRY FORM

Type of inquiry: Claim Status Rejection Questioned Payment Amount Questioned Network Availability

Billing Provider Name (Last, First, MI)		Provider ID Number	
Street Address		Name of Contact Person	
City	State	Zip	Telephone ()
			Fax ()

Member Name		Patient's Name	
Member ID		Check Number	
Date of Service	Amount Billed	Date of Check or EOB	
Claim Number		Place of Service	

Detailed Inquiry:

Reserve National Insurance Company addresses and resolves provider inquiries related to the processing of claims as quickly as possible. If you would like us to investigate the way Reserve National has processed a particular claim, please complete this form and send it to us, along with the statement of remittance and any supporting documentation via fax to (405) 254-2111 or via mail to the following address:

Reserve National Insurance Company
601 East Britton Road
Oklahoma City, OK 73114