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