MEDICAID RESOLUTION INQUIRY

Please Place an "X" in Only One Type:
___ Medicare Override
___ Time Limit Override
___ Time Limit Override with Medicare
___ Time Limit Override with TPL
___ Time Limit Override with Medicare and TPL

NOTE: PLEASE USE THIS FORM FOR **OVERRIDES ONLY**.
CLAIM, RAs, AND ALL RELATED DOCUMENTATION MUST BE ATTACHED.

National Provider Identifier (NPI): ______________________

Provider Name and Address: ____

____

Patient's Name: _________________________________ Recipient ID: ________________________

Date of Service: From: / / to / / Claim Number: ________________________

Billed Amount: _____________ Paid Amount: _____________ RA Date: ____________________

Comments:

Signature of Sender: Date: Phone #:

TO BE USED BY CSRA ONLY

Remarks:

MAIL TO:
CSRA
P O BOX 300009
RALEIGH, NC 27622

Revised 2/3/14 upd