CLEAR FORM

Medical Records Submission Form

Physicians Health Plan

NOTE: *Use of this form is for the purpose of submitting Medical Records and/or additional information as requested. Do not use this form for claim inquiries, disputes or appeals.*

Date of Submission:

Member Name:

Member Number:

Date of Service:

Claim Number:

Provider Name:

Provider Number:

Address:

Contact Name:

Contact Phone Number:

Please choose the appropriate box and description below:

☐ **Medical Records Request**

Explanation of Payment (EOP) Denial codes: **QG7, QH0, QL1, QN3, QN4, QN5, QN6, QN7, QN8, QP2, QR2, QR4, QR6, QR7, QR8, QS5, QT1, QT3, QT4, QW5, QW6, QW7, QX1, QX2, QX5, QX6, QX8, QX9, QY1, QY2, QY4, QY6**

RG7, RH0, RL1, RN3, RN4, RN5, RN6, RN7, RN8, RP2, RR2, RR4, RR5, RR6, RR7, RR8, RS5, RT1, RT3, RT4, RW5, RW6, RW7, RX1, RX2, RX5, RX6, RX8, RX9 , RY1, RY2, RY4, RY6

Send to: **Change Healthcare**

☐ **Itemization / Implant Log Request**

Explanation of Payment (EOP) Denial codes: **QR4, QN6, QN7, QX3, QX4, QX7, RX3, RX4, RX7, RN6, RN7, RR4**

Send to: **Change Healthcare**

Change Healthcare

Fax: 949.234.7603
Email: medicalrecords@changehealthcare.com
Mail: Change Healthcare
Attn: Pre-Pay
1849 West Drake Drive, Suite 101A
Tempe, AZ 85283

☐ **Medical Records Request**

Explanation of Payment (EOP) Denial codes: **490, 590, 690, 4G5, Q21, R21**

Send to: **Physicians Health Plan (PHP)**

☐ **Other** (please provide detailed information):

Send to: **Physicians Health Plan (PHP)**

☐ **Itemization/Invoice Request**

Explanation of Payment (EOP)
Invoice Denial codes: **430, 530, 540, 630, 730**
Itemization Denial Codes: **482, 4F9, 5F9, 582, 682, 782**

Send to: **Physicians Health Plan (PHP)**

Physicians Health Plan

Mail: PHP - Physicians Health Plan
PO Box 313
Glen Burnie, MD 21060-0313