

**MEDICAID RESOLUTION INQUIRY**

MAIL TO:  
HP ENTERPRISE SERVICES  
P O BOX 300009  
RALEIGH, NC 27622

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Please Check:  Medicare Override  Time Limit Override  Third Party Override  Medicare HMO

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

**ADJUSTMENTS WILL NOT BE PROCESSED FROM THIS FORM.**

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Provider Number: \_\_\_\_\_

Provider Name and Address: \_\_\_\_\_  
\_\_\_\_\_

Patient's Name: \_\_\_\_\_ Recipient ID: \_\_\_\_\_

Date of Service: From: / / to / / Claim Number: \_\_\_\_\_

Billed Amount: \_\_\_\_\_ Paid Amount: \_\_\_\_\_ RA Date: \_\_\_\_\_

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Please Specify Reason for Inquiry Request:

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Signature of Sender:

Date:

Phone #:

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**TO BE USED BY HP ONLY**

Remarks: