Reset Form

Ohio Department of Medicaid

MEDICAL CLAIM REVIEW REQUEST

1. PROVIDER INFORMATION

Provider Name _____

Address _____

City _____

State _____ Zip _____

Contact Person _____

2. SUBMISSION DATE OF THIS FORM

___/___/___

Individual Provider # ___ ___ ___ ___ ___ ___ ___

Group Provider # __ __ __ __ __ __ __ *(When appropriate)*

Telephone # (____) _____

3. CLAIM INQUIRY INFORMATION

Recipient Name _____

Billing # (12 digits) _____

Service Date _____

or

Discharge Date _____

4. CLAIM HISTORY INFORMATION

Transaction Control Numbers

TCN _____

TCN _____

TCN _____

Please note: All transaction control #s are 17 digits

5. Please enter all applicable Medicaid E.O.B. denial codes, which apply to the attached claim.

EOB _____ EOB _____ EOB _____ EOB _____

(Please include all necessary documentation, e.g. remittance advices, Medicare and/or Insurance EOBs).

6. Explanation of request:

_____

_____

_____

_____

_____

_____

Internal Use Only

Date of Receipt Stamp

MEDICAID USE ONLY

☐ Claim not approved for processing, please see the attached letter.

Reviewer ID _____

Each claim requires a separate ODM 06653 Medical Claim Review Request Form
Please call our Interactive Voice Response Unit (IVR) at 1-800-686-1516 for claim status verification.