

# CLAIMS INQUIRY Form

Please complete this form and attach appropriate documentation.

Mail to: **Mississippi Medicaid Program**  
P.O. Box 23078  
Jackson, Mississippi 39225



## 1 Provider Information

### 1a Billing Provider Number and/or Servicing Provider Number

### 1b Provider Name and Address

### 1b Point of Contact

### 1c Provider Telephone

## 2 Beneficiary Information

### 2a Name

### 2b Recipient ID Number

### 2c Date(s) of Service

### 2d Transaction Control Number (TCN)

## 3 Nature of Inquiry (Please check one of the following if applicable, if not please explain in the space below)

3a Claim Status

3b Explanation of denied Claim

Other Inquiry:

## 4 Signature Block

### 4a Signature

### 4b Date

## Mississippi Medicaid Use Only

Reviewed by

Date Stamp

Action Taken