MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS®

CLAIM REVIEW REQUEST

Complete and return this Form to ANTHEM or MOTION PICTURE PENSION & HEALTH PLAN (MPI) as indicated below. Fields with an asterisk (*) are required.

Provider Data				
***Treating Physician or Provider Name**			**Today's Date**	**# of Pages**
National Provider ID Number	**Tax ID Number**	**Contact Person**		
Address				
City			**State**	**Zip**
Email		***Phone** / **Ext**		**Fax**

Claim Data * For Multiple claims disputed for the same Participant / Member		
***Claim Number**	***Date of Service**	***Patient's Name**
***Participant's ID Number**	***Participant's Name**	

Type of Review

Mail to: MPI **P.O. Box 1999** **Studio City, CA 91614**	**Mail to: Anthem** **P.O. Box 60007** **Los Angeles, CA 90060**
☐ **Eligibility**	☐ **Contract Pricing**
☐ **Information Requested on EOB**	☐ **Corrected Claim (Diagnosis, CPT, Units, etc.)**
☐ **Medical Records**	☐ **TIHN Referral**
☐ **Other _____**	☐ **Request for Primary/Secondary Explanation of Benefits**
	☐ **Claim Extend**

Reason for Review – *REQUIRED (Please state your reason in the space below)

Attach and list the documentation provided to support or facilitate our review. (e.g. Operative Report or Medical Records)

PLEASE NOTE: * A valid Claim Number is required for processing. Forms submitted without this information will be returned.