

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