



INDEPENDENT CARE HEALTH PLAN

Attn: Claims

Phone: 414-231-1029

Fax #: 414-231-1094

STATUS CHECK REQUEST FORM

Facility Name: _____

Contact: _____

Fax #: _____

Phone #: _____

Acct #: _____ Member Name: _____

Member ID #: _____ Date of Service: _____

Billed Amt: _____ Performing Provider: _____

Response: _____

Acct #: _____ Member Name: _____

Member ID #: _____ Date of Service: _____

Billed Amt: _____ Performing Provider: _____

Response: _____

Acct #: _____ Member Name: _____

Member ID #: _____ Date of Service: _____

Billed Amt: _____ Performing Provider: _____

Response: _____

Acct #: _____ Member Name: _____

Member ID #: _____ Date of Service: _____

Billed Amt: _____ Performing Provider: _____

Response: _____

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