

Provider Inquiry Email Form

This form includes information that Medicaid Provider Relations/Support Services needs to answer most inquiries. Once you have downloaded this document, complete and save the form to your computer and attach it to your email to ProviderSupport@michigan.gov. E-mail response turn-around time is typically 3-5 business days. Please do not include PHI sensitive information in the e-mail subject line.

*The portions marked with red asterisk are suggested to be completed in detail-if not applicable to your inquiry please mark N/A. Please be as specific as possible when completing the Issue/Question portion under Claim Information.

Provider Identification Information:

*Provider Representative Name/Credentials:

*Provider Name:

*Provider National Provider Identification Number (NPI):

*Provider Tax ID:

*Provider Phone Number and Extension:

*Provider Type - Select one from the following options:

Institutional:

Practitioner:

Dental:

Other:

Provider Fax Number:

Provider Physical Location Address (MUST be completed for response via USPS):

Provider Email Address:

Claim Information:

*TCN(s):

*Procedure Code(s):

*Claim Adjustment Reason Codes from the MDHHS Remittance Advice:

*Remittance Advice Remark Codes from the MDHHS Remittance Advice:

*Date of Service: From: _____ To: _____

*Beneficiary Medicaid Identification Number:

*Issue/Question:

*Documentation for this issue may be uploaded to the DMP:

If you wish to send your inquiry via USPS print this document and send to: MDHHS/Provider Inquiry PO BOX 30731 Lansing, MI 48909-8231