HEALTHPLEX
THE DENTAL BENEFIT EXPERTS℠

Provider Inquiry Request for Clarification
Regarding Claims/Bulk Checks/Predeterminations/Member Eligibility
Fax to (888) 468-2184

Provider TIN# or Site # _____ Provider Name _____ Fax Back to Office ◯ Call Office ◯

Provider Phone # _____ Provider Fax # _____ Requested by (Name) _____

PATIENTS NAME	PATIENTS ID #	PATIENT D.O.B	PATIENT ELIGIBILITY NEEDED?	CLAIM, PRE-D OR BULK CHECK NUMBER	BULK CHECK DATE AND AMOUNT	SUMMARY OF ISSUE REQUEST	HEALTHPLEX RESPONSE

Please fax this form to (888) 468-2184 for Eligibility, Claims/Predetermination and Bulk Check inquiries.
A Response will be provided through either a fax or phone call to the office within 2 Business days.

Assigned to: _____ Date: ___ /___ /_____

Healthplex USE ONLY