

Claim Inquiry Form

Completion Instructions



- First contact [Empower Provider Services](#) (855-429-1028) to address the issue or question. Always record reference or ticket #s and the representative's name.
- If resolution cannot be reached, [complete](#) this form and forward to [Empower Provider Relations](#) by secure email or fax.
- Include all relevant documentation per the bottom section of the form.

Type of Dispute

- Claims Denial
 Underpayment
 Provider Enrollment / Participation Issue
(Include claim info if relevant)

Provider Information

Provider Name:	
TIN:	
Contact Name:	
Phone:	
Email:	

Member & Claim Information

Member Name:	
Member Empower ID:	
DOB:	
Claim Number (include EOB):	
Authorization Number:	
Dates of Service:	

Description of Dispute Reasoning

Initial Resolution Outreach

Date of First Call:	
Reference Number:	
Name of Associate:	
Additional Corespondance:	
Results / Response from Payer Outreach:	

Documentation Attached

- Member ID Card
 Additional Claim Notes
 Other (Describe): _____
 Claim Copy
 Pre-Cert / Authorization Approval _____
 EOB / Rejection Letter _____

Please submit form with all relevant supporting documentation to empowerhealthcaresolutionsPR@empowerarkansas.com or by fax at 888-614-5168.